

DOCUMENT RESUME

ED 145 511

95

EA 009 959

AUTHOR Hochman, Gloria, Ed.
TITLE Management in Social Welfare: Casebook Studies.
INSTITUTION Pennsylvania Univ., Philadelphia. School of Social Work.
SPONS AGENCY Department of Health, Education, and Welfare, Washington, D.C.
BUREAU NO SRS-84-P95411/3-02
PUB DATE 76
NOTE 249p.; Published by the National Project on Education for Management in Social Welfare; For a related document, see SO 010 006
AVAILABLE FROM Dr. Elisabeth M. Schaub, National Management Project, University of Pennsylvania School of Social Work, 3701 Locust Walk, Philadelphia, Pennsylvania 19174 (\$5.95)
EDRS PRICE MF-\$0.83 HC-\$12.71 Plus Postage.
DESCRIPTORS Bibliographies; *Case Studies; Higher Education; Instructional Materials; *Interdisciplinary Approach; *Management Education; *Social Agencies; *Social Welfare

ABSTRACT

This publication consists of 18 case studies dealing with the management of social welfare programs and is intended mainly for use by the faculty and students of interdisciplinary studies in management/social work. The case studies have been gathered from voluntary and public agencies that provide a wide range of social services and are located mainly in the northeastern United States. Of the 18 case studies, 13 are followed by commentaries by an educator in business management and an educator in social work, which include recommended study questions and readings relevant to the particular case study. (JG)

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MANAGEMENT IN SOCIAL WELFARE:

CASEBOOK STUDIES

PUBLISHED BY

THE NATIONAL PROJECT ON EDUCATION FOR MANAGEMENT IN SOCIAL WELFARE

Under the auspices of

The School of Social Work

and

The Entrepreneurial Center, Wharton School

University of Pennsylvania

1976

This book was supported by a grant
from the U.S. Department of Health,
Education and Welfare, Social and
Rehabilitation Service, Project #
SRS 84-P95411/3-02

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ACKNOWLEDGEMENTS

We wish to express gratitude to the managers, their clients and staff members who were integrally involved in the case studies in this volume. We are indebted to them for generously sharing their experiences with us.

Our special gratitude to Seth Low,
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We appreciate the efforts of the members of our Advisory Committee who arranged for us to meet executives and to have access to social welfare agencies to request case material for this book of studies.

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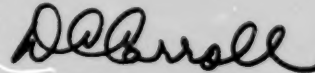
PREFACE

The continuation of the Project on Education for Management in Social Welfare permits publication of this volume, which is an additional testimony to the value of a joint program between a School of Social Work and a School of Management.

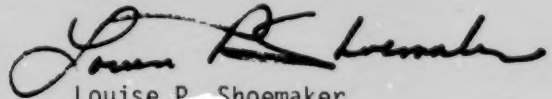
All of society is concerned with the solution of complex social problems and looks to personnel with the commitment and the competence to implement effective solutions. Universities, through graduate programs and continuing education, must develop managers with that kind of combination of conviction and expertise.

The University of Pennsylvania has been and continues to be involved in the interdisciplinary approach to provide a basic education for better management of social service programs. New courses have been developed and curriculum has been re-designed. Innovative approaches to management education for social welfare are being explored.

This casebook, produced through a grant from the Social and Rehabilitation Service, United States Department of Health, Education and Welfare, will, we hope, be useful to educators, like us, in other universities concerned with developing interdisciplinary approaches to management education. We, at the University of Pennsylvania, are pleased to be able to publish it.



Donald C. Carroll
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INTRODUCTION

A turbulent society, with its increasingly complex human problems, has placed demands on social agencies that require more efficient, effective, and innovative management.

To meet this demand, schools of management and social work are increasingly collaborating in order to offer interdisciplinary management education to their students. This volume is intended for use by teachers in these schools and by students, as a supplementary text.

The case studies have been gathered from voluntary and public agencies mainly in northeastern United States. Agencies represented cover a wide range of social services--medical, child welfare, mental health, public welfare and others and reflect the managerial functions, responsibilities, dilemmas and decisions pertinent to each. Managers described include those at the top level, their assistants and those in mid-management positions. Some cases cover situations and initiatives that span a period of time. Others focus on short-term problems.

Every aspect of social welfare could not be covered. However, the cases selected reflect some of the areas of management that, we believe, merit special attention. They are the following:

External Environmental Relations:

Organization of social welfare services; Political processes; Legislative processes; Interagency cooperation; Policy analysis; Understanding, assessment and evaluation of the organizational environment; Consumer participation/citizen participation.

Program Development:

Planning methods (PERT, PPBS, etc.); Operations research; Organizational analysis; Decision theory.

Program Implementation:

Administrative structures, roles, functions; Administrative leadership; Administrative strategies and tactics; Values and ethics of social service administration.

Program Evaluation:

Operations research; Cost benefit analysis; Systems analysis; Quantitative methods; Quality control methods.

System Change:

Organizational analysis; Goal formulation; System restructuring; Management of organizational conflict; Organization development.

Fiscal Management:

Budgets and budgeting; Fiscal control; Funding sources and allocation procedures; Grantsmanship; Cost analysis; Accountability.

Personnel Management:

Job analysis; Collective bargaining; Professionals in organizations; Supervision; staff development technologies; Grievance procedures; Conflict management; Contract administration; MBO

Information Systems:

Types of information systems, capabilities, costs; Output utilization; Issues of confidentiality; Presentation of human values and quality service values in management information systems; Computer technology.

This volume includes thirteen case studies - each amplified by commentaries from an educator in business management and an educator in social work, including recommended study questions and readings. Preceding the commentaries, there is a review of the utilization of case studies in education for business management and social welfare.

Five case studies without commentaries complete the volume. These have been included so that interested teachers and students can approach them with their own frame of reference on managerial accountability and practice. In our view the basic knowledge and skills of business management should be integrated with those of social work within a framework of social work values.

Future volumes, representing an extension of this project, will focus on other areas and reflect the fast-changing functions and scope of social welfare programs and management.

Elisabeth M. Schaub

Elisabeth Schaub, D.S.W.
Project Director

UTILIZING CASE STUDIES IN EDUCATION FOR MANAGEMENT

by Arthur Rosenfeld, M.S.W.

Historically, social work students have received much of their practice education through extensive use of case material--both prepared cases and the student's process records from practice settings.

A major teaching goal has been and continues to be for students to gain insight from their own work, or work of others, about social work processes. Other objectives are (1) to help students develop an analytic approach to problem solving in a bureaucratic environment and (2) to prepare effective managers, who, in Penchansky's terms, "can see problems, define them operationally, and can separate the important considerations from the unimportant and the policy issues from the individual ones."¹

The case method has been a cornerstone of the Harvard Business School. The program's first catalogue in 1908 referred to the "problem method" where materials are used for "meaningful analysis by students."

In education for social work management, the substantial work of Harry Schatz, "A Casebook in Social Work Administration," (1970)² is still widely used. Schatz points out that the case method bridges the classroom with the real world, by confronting the student with "the necessity of applying his theoretical knowledge with imagination, critical analysis, and judgment as he moves into complex life situations....."

Recently, the method was explored by Sprague, et al, in "Teaching Health and Human Services Administration by the Case Method."³ He says the case method "provides the methodology that permits the student to continue to learn and to improve administrative skills throughout his or her professional life."

We know from learning theory that "practice in applying principles to the solution of problems....increases the probability of transfer of the training to new

problems,"⁴ and that learners will respond more efficiently when they make the responses to be learned than if learning by observation.

The case method embodies these principles through what Grogg labels the "dynamic operation of the learner."⁵ Penchansky stresses that the most important contribution of the case method is in the "development of skills in problem-solving and decision-making, planning for implementation, and the provision of an action orientation."⁶

Schatz and others have emphasized the importance of human relationships in administrative decision-making and the value of case analysis in studying those relationships. Niland summarizes positive characteristics of the case method:

1. Realism--interesting material is presented and the student is placed in possible real-life situations.
2. The student gains experience in performing essential parts of administrative tasks.
3. Students form habits in making decisions, learning to cope with time constraints and developing judgment.
4. Students acquire interrelated knowledge about other fields.
5. Students are forced to think analytically.⁷

As in any teaching methodology, the instructor's skill is crucial. Dearborn⁸ has identified five primary roles performed by the instructor: discussion leader, resource leader, helpful expert, evaluator or summarizer, judge of performance.

Faculty must be aware, however, of disadvantages of the case method, as pointed out by Renthal⁹ and Penchansky¹⁰. Instructors must: (1) emphasize that while case material reflects real administrative problems, the actual administrator must act quickly under stress, without the luxury of time for reflection; (2) give students feedback on their analysis and permit them to see the consequences of their decisions; (3) regulate information flow about the case to assure that students learn to gather facts independently; (4) assure that the focus of the case analysis remains broad, without focusing on obscuring trivia; (5) assure that discussion remains consistent with the educational objectives for the course and the larger

objectives of social work education.

Perhaps the best comment on the case method comes from Gross, the Harvard Business School authority. He says, "In every business situation, there is always the possibility that the best answer has not yet been found....even by teachers."¹¹

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ORGANIZING A RESPONSE TO PROPOSED CUTBACKS IN
FUNDING FOR SERVICES TO THE AGED

by Dr. Erwin Carner, Arthur Rosenfeld, M.S.W. and Rodney Williams

In mid 1975, the Philadelphia Corporation for Aging (the funding conduit for Aging services in Philadelphia) discovered that state appropriations for 1976 programs were not sufficient to sustain even current funding levels. Proposed budget appropriations would have cut homemaker service, multi-service senior centers, and other specialized services by 40%, and would have made it impossible for the Philadelphia Corporation for Aging to fund six additional programs, which included three already funded under a direct contract with the State, and three that were in preliminary stages.

During a two month period (July-August, 1975), the combined efforts of the Philadelphia Corporation for Aging, sub-contracting agencies, the Action Alliance of Senior Citizens (100,000 members) and program participants succeeded in increasing appropriations for the Southeastern Region.

This study will show the care that was given to each decision and demonstrate how each move was calculated to bring maximum pressure on State officials. The case is presented from the viewpoints of both the Director of The Philadelphia Corporation for Aging and the Director of Older Adult Services of one of the city's Mental Health Centers who played an important role.

On July 5, 1975, proposed Title XX allocations (for Social Services) were proposed in the Pennsylvania Bulletin. A 90 day period for public comment was required before the final State plan could be published. The proposed total state allocation for Aging services was 22 million dollars. The proposed allocation to the Southeastern Region (Philadelphia, Montgomery, Chester, Bucks, and Delaware Counties) was 7.5 million dollars, the amount required by Philadelphia County alone to continue current contract obligations. This did not include funding for new programs recently approved by the State's Regional Office of the Department of Public

Welfare and scheduled to begin serving clients July 1, 1975.

While several project directors were aware of the problems, the full implications of the funding crises were not apparent until the Philadelphia Corporation for Aging (Area Agency for Aging-AAA) director presented a detailed analysis of the State plan at a budget planning meeting on July 10-11, 1975. A quick plan of action was mobilized.

After the fiscal meeting, an ad hoc committee of P.C.A. staff and project directors met on an emergency basis to develop strategy for the upcoming state hearings the following Tuesday. Under usual circumstances, a senior citizens lobby takes the initiative in organizing such campaigns; however, the time pressure, combined with P.C.A.'s desire to fulfill its advocacy role, led P.C.A. to direct this effort. Three key decisions were made: 1) that older adults be present at every hearing (State-wide and regional) and that P.C.A. direct all press coverage of these hearings, 2) that the essence of testimony be directed toward receiving more funding for services to aging but not at the expense of other fields of service, and 3) that concerns be presented on a regional, not a Philadelphia, basis.

On Monday, July 14, P.C.A. and the Southeastern Region Governor's Council on Aging arranged a press conference to make the funding concerns a matter of public record.

The next day, 250 older adults descended on the State Hearings in Harrisburg. Within a few days, staff had to arrange buses, pick-up points, lunches, rest stops, speech writing, etc. Besides the dramatic impact of the testimony, participation in these hearings generated enthusiasm among members of delegations (recipients) about the roles older adults could play in defending their own interests. They carried this enthusiasm to their Centers and helped others become politically aware. A great sense of comradeship developed--a feeling that as a group they had strengths and their voices could be heard.

On July 17, there was an emergency P.C.A. Board Meeting to discuss continued strategy and P.C.A.'s leadership role. The Board supported the use of the agency's funds and resources, and decided to pursue a meeting with the Governor.

On July 18, P.C.A. arranged a mass meeting for senior citizens at the Philadelphia Community College to demonstrate for the press what it would mean if services were cut.

On July 21, public hearings on Title XX were held in the Southeastern Region. Dramatic testimony on aging was given by the President of the Action Alliance, Area Agencies on Aging, Service Providers, and participants.

While public pressure was being applied, activities were intensified behind the scenes. Legislators were personally informed of the seriousness of the problem and invited to come to Senior Centers to see the activities and the problems that would be created by the proposed cuts. In addition, a network of communication with the ten largest AAA's in the state was developed, stressing the importance of testifying for aging services at local public hearings. These effects were all part of an intensive public relations campaign.

On August 4, the State placed a freeze on all Title III funds (Older Americans Act), refusing to allow any budget revisions on contracts already signed, and refusing to sign contracts for new programs already approved by the region. One such program was a meals-on-wheels program that committed two meals a day to people recently discharged from institutions. The AAA Directors' immediate response was to personally meet with the Commissioner on Aging. He would not rescind the cancellation of the program, but did allow the service to the initial group of clients who had already been assigned to receive it. This was a significant development because it demonstrated that top level decisions could be modified by appropriate personal intervention!

On August 13, AAA Directors met with the Regional Secretary of D.P.W. At this

time, each county was officially informed of its share of the regional allocation. Philadelphia was to receive 5.8 million dollars of the 7.5 million allocated for the region. These figures were based on the original Pennsylvania Department of Public Welfare Title XX allocation plan and indicated that no fiscal changes had been made.

Although dismayed by the apparent lack of any concrete changes in the allocations, the aging advocates decided to direct their efforts towards a massive response to the final State hearings in Harrisburg. Philadelphia brought 1200 people, almost all recipients, on buses to appear at the hearings.

Upon arriving in Harrisburg, the AAA Director learned of a chance to meet with the Governor, arranged for ten key Philadelphia leaders to do so.

The meeting started with the State Welfare Secretary as Chairman in the Governor's absence. At that time, the President of the Action Alliance of Senior Citizens indicated that the group would speak about the allocations only with the Governor. While waiting for the Governor, two other issues were discussed, and some victories for the recipients were achieved. These included a pledge by the Secretary to involve the recipients in redesigning eligibility forms (Means Test), if, indeed, the Means Test could not be abolished, and a pledge to work at the Federal level for changes to permit group eligibility for older persons.

When the Governor appeared, he listened intently and seemed genuinely interested. He dismissed himself indicating he would return shortly. (Later reports noted that he had a meeting with his Budget Secretary). He returned and told the group he had authorized the Welfare Secretary to spend an extra \$2 million for State Wide Aging Programs. (Although not explicitly stated, it was understood that this money would come to Philadelphia). He also pledged to direct the Secretary to explore other state and federal sources for additional money for aging programs so that all current programs would be maintained and that the six new programs already

approved would be funded. This pledge was most important to the organizers. They were not as concerned with exact dollar figures as they were with obtaining a pledge to avoid cutbacks.

A key administrative follow-up to this meeting was a letter to the Governor from the AAA Director outlining his sense of the agreements reached at the meeting. (Attachment A).

Summary

The efforts were successful because of the care taken in preparation at every step of the process. Key staff efforts included:

- 1) Briefings of recipients so that they would make knowledgeable presentations at hearings and to the press.
- 2) Concise testimony and presentations at hearings and to the Governor with an emphasis on facts and figures.
- 3) Responding to the Governor on a personal and emotional level.
- 4) Recording and verifying all agreements.
- 5) Coordination of efforts to contact legislators and utilize them effectively.

Conclusion

Under duress, professionals from many agencies formed a coalition to coordinate myriad activities aimed at maximizing pressure on State officials. The gains made by this coalition of professionals and recipients will not solve the long range funding problem, but they did avert a disaster and provide time to find additional financial resources. Future efforts to mobilize a diverse group of professionals will be made easier by this experience.

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Elisabeth Schaub

This case is focused on the political process by which the administrator and his staff delay and defeat State cutbacks in appropriations for programs for the Aging. Their mobilization efforts with consequent pressure on State officials is successful and effective, at least for the present. The appropriations are restored. But what of the future?

Questions to Consider

1. This administrator considers his political accountability to be as important a part of his role as his accountability for fiscal management and for program development. Should someone in his position hold himself politically accountable in this way or not? To what community interest groups, or others?
2. What components of administrative skill are well demonstrated in this campaign for restoration of the cut-backs in funds for programs for the Aging?
3. What constraints on this public program, and others like it, hamper long range administrative planning to win the support of appropriate interest groups for it?
4. Considering various theoretical approaches to administrative practice, which one do you think offers the most to administrators who must cope with apathy or hostility to politically vulnerable social welfare programs?
5. What special expertise do administrators need to create on-going community support for public programs like this? How can they develop it?

Related Readings

1. Etzioni, Amitai. "Alternative Conceptions of Accountability," Hospital Progress, 55(6), June, 1974.
2. Jackson, Hobard C. "National Goals and Priorities in the Social Welfare of Aging," in The Gerontologist, 2(1971), pp. 226-231.
3. Morris, Robert and Ollie Randall. "Planning and Organization of Community Services for the Elderly," Social Work, 10, January, 1965, pp. 96-103.
4. Rothman, Jack. Planning and Organizing for Social Change. N.Y.: Columbia University Press, 1974, p. 38.
5. Warren, Roland. The Structure of Urban Reform, Lexington, Mass., Lexington Books, D.C. Heath and Co., 1974.
6. Reader on Human Service Planning; Alternative Approaches to Human Service Planning; Needs Assessment In Title XX State Service Planning Systems; Goal and Objective Setting In A Title XX State Social Service Planning System. Pamphlets published by Human Services Institute for Children and Families, Inc., Washington, D.C., April, 1975.

COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

Long term goals are composed of the integration of short range objectives. In this situation it may well have been that the agency's funding has been maintained for one more year because of the advocacy organized and effectively implemented.

The question, however, is whether the enormity of expenditure of effort and the use of the clients as an influencing source are the best use of the total efforts and, more importantly, whether the agency itself properly perceived of its long range objectives and effectively directed its efforts toward those ends.

One of the goals, obviously, of any agency supported by public funds, is the receipt of adequate funding. But, such funding comes as a result not merely from the pressures of the clients. Client pressures are a means of convincing the administrators, executives and particularly the legislators as to the need or requirement for such funding. Picket lines, petitions, public demonstrations and sit-ins are "media" happenings. Truly, if the short range objective is to obtain attention, this approach achieves gratification of those needs.

Be that as it may, the long range objective, namely, that the funding has been placed on a proper basis, has not been resolved. Public image of the agency and its programs is one of the priority goals of any organization. Public information and the development of the client needs and program details demand that these be developed and implemented over a period of years to indicate the cost benefit of these programs. This public perception of the value of the program is of more value and of longer duration than the "one shot" crisis response.

While certain psychic satisfactions are obtained in having "beaten into submission" the administrators or having achieved a remission or revision of the decisions, this type of ad hoc response wears thin with the media, the clients and those who are influenced.

Ad hoc is exactly that. It is impressive for the moment, but the efforts of the administrators of the program have been dissipated to the ultimate disadvantage of the program and the organization itself. Time and effort are being spent away from program objectives and the clients are being "used" sometimes, less for program continuation, than for agency employee security and continued employment.

Related Readings

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Polsby, Nelson W., Political Promises, Oxford University Press, 1974, 200 Madison Ave., N.Y., 10016.

ON PLANNING

by Jerry E. Griffin, Ph.D.

The Community Council of a southeastern metropolitan area of 125,000 population had applied for and received a planning grant for a much-needed service. In order to qualify for the grant, a special governing committee was set up to guide the planning period (and any subsequent programs that might be funded). The committee consisted of 50 persons, drawn from racial, ethnic and income minorities, from elected officials and from civic and social welfare organizations in the area. Many persons on the committee had worked hard to get the planning grant and had made trips to federal regional offices to plead for support, receive guidance, and rework the proposal. Community Council staff had become heavily involved in developing the planning phase but did not anticipate heavy involvement, once the project was funded and a staff director was hired. The board of directors of the Community Council had not wanted to change its membership to conform to federal requirements but did agree to set up the large steering committee, giving it complete authority over the new program. The government was therefore satisfied that the project could operate properly and funded the program.

A well qualified social worker was employed to direct the project. During the first three months of the planning year, he employed two additional professional staff, a secretary and a bookkeeper. The staff spawned and guided several data development projects that were essential for long range planning and project proposal development for the coming year. He met weekly with a small administrative committee that was drawn from the larger steering committee of 50, keeping them posted on all developments, soliciting their advice and consultation. The larger steering committee met monthly and participated in all major decisions concerning the project. Generally, the project proceeded well, and gained a great deal of popularity with persons it was eventually intended to serve. Elected officials were somewhat edgy about the

cooperation with Federal guidelines for integration at all stages, but made their peace with that in the face of prospectively large sums of money to be brought into the community.

During the seventh month of the planning year, the Community Council held its regular annual meeting. One third of its board members were replaced and a new board chairman was elected. The chairman, in response to his unanimous election, made the statement that he had hardly ever heard of the Community Council in this town, where he and his father before him had been businessmen, until he was approached to be its president. He was honored and pleased to be asked to serve and promised to apply his best business judgment in guiding the affairs of the Council. He was loudly applauded for his brief speech. In the following days, the director of the federally supported planning project paid a call on the new Council president, accompanied by the Council's executive director. The Council executive was not an academically qualified professional, but had a good track record in raising money through United Way organizations. He also served as executive of the local United Way and his salary was paid entirely by that organization.

The visit to the new Council president was to interpret to him the various aspects of the planning grant the Council had undertaken and to explain the role of the large steering committee. Copies of several important documents were shared with him, including a resolution by the Council board giving authority to the steering committee of the planning project, dated several months earlier. The president was most gracious in expressions of appreciation for the materials we had brought, listened intently in the discussion and even took a few notes.

At the next meeting of the Council board, the president distributed a plan for the Council's reorganization in relation to the planning project committee. He pointed out that there was no written requirement from the federal government that

the committee be given such authority (the pressure had been vocal by the federal staff; they had requested the board resolution as written assurance). He also pointed out that the authority given to the committee was that which is usually retained by a board of directors and that it would be consistent with good business practices to give those powers to the board of the Council. The large committee would simply provide advisory functions for the board. Project staff would be brought under the direction of the Council executive. The Council executive appeared both pleased and perplexed at this sudden forceful show of leadership by the president. The chairman of the large steering committee, who was a member of the board, indicated that such a move might cause difficulties in securing federal funding for additional projects; the president countered with, "We'll cross that bridge when we come to it." The plan of reorganization passed, unanimously, except for the steering committee chairman's abstention.

Immediately after the Council's action, the executive director notified the planning project director and shared a copy of the reorganization plan. Shortly thereafter, the planning director called the appropriate federal office to inform them of the action and was told that this would result in a total shutoff of federal funds, including an additional \$200,000 project that had been approved two months earlier and which was already in operation with a client group of 200 persons. The shutoff of funds was to be effective in 30 days.

Immediately the planning project director called the entire project staff together to study the reorganization and its implications. All new jobs were at stake, as well as all funds currently coming into the community through the project (anticipated maximum of \$1,000,000 per year). Services that had been needed for many years were finally being provided and a major sector of the community was getting help for the first time.

The Council executive was not regarded as capable of understanding the implications of this action other than the fact that his ego was temporarily enhanced by reorganization of project staff reporting channels. Since his salary came from United Way funds, he was unlikely to fight for a reversal of the council board's action. In addition, he was in his third year of a five year contract with United Way. It would be of little use to create any more difficulties for him than he already had (some members of United Way board had already sought ways to break his contract to terminate his service).

The Council president was more admired for his local business achievements than he was evaluated by Council board members. The board was impressed with his business acumen and would not likely be persuaded to go against his wishes (many had loans through his bank, to operate their own businesses).

Several members of the project steering committee had exhibited genuine interest in and dedication to the efforts of the project and had been willing to cooperate with federal guidelines in the past. The chances appeared good that 10 such persons could be identified, who would serve as incorporators of a new agency to run the project.

The federal funding agency was contacted again and provided assurance that all funds could be transferred to a new corporate structure that met its guidelines, without loss of money or staff. The project staff then, working through the steering committee chairman, raised money for legal fees to incorporate, found 10 incorporators, and filed papers of incorporation. Some matters took more than 30 days to achieve but were made effective soon enough not to cause difficulty (Internal Revenue Service status as a non-profit corporation, for example). No staff time or payroll losses were suffered; discussions were held with key persons throughout the community, including the Council board, to ease the transition. The Council was eventually satisfied that it had served an appropriate function in initiating the planning

project, and that it had appropriately achieved independent corporate status. The Council president served a one year term and has returned to his business affairs. The Council executive moved to another community a year before his contract expired when he learned that it would not be renewed. The newly incorporated service agency completed its year of planning with success and continues to flourish in the community, now receiving strong local as well as continued federal support.

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Phyllis Freeman

During the sixties and early seventies, many federally funded programs emerged, utilizing the concept of citizen participation. Federal guidelines demand documentation of representative numbers and substantial ongoing involvement, theoretically insuring that the interests of the "consumer" are protected because of his input in decision-making. However, citizen participation is often sabotaged or curtailed, usually leading to abolishment, as illustrated when the President of the Community Council rescinded the power of the planning committee.

More central in this case, however, is the conflict engendered when dissimilar organizations, having differential power and control, had to collaborate to achieve a specified goal. Vested interests and organizational loyalties of key administrative officials further weakened the cooperative process. Huse and Bowditch contend:

Whatever criteria are used to categorize an organization's goals, however, it must be kept in mind that in and of themselves, organizations do not have objectives; rather people have objectives, stemming from their own views and motivations. Thus, so-called "organizational objectives" are really uneasy and shifting compromises among the individuals within the organization and the demands made by the outside environment.

Thus, the goals of the Community Council and the planning committee were subordinated to the manipulation of those in control. The committee found itself divested of its role. The "means" for accomplishing the "end" (objective-service) shifted, and power and control were used to usurp the less formal organization's input. Huse and Bowditch call this interplay "proactive vs. reactive approaches to objectives."

...Reactive forces cause organizations to cling to objectives or procedures that are actually harmful to the organization... The other is the force that works toward change in the system, of "proactive" force.

A useful theoretical construct, developed by Keith Davis, examines the four models of organizational behavior--autocratic, custodial, supportive and

collegial-- in relation to several variables. Here, there are two organizations at opposite ends of a continuum--one highly autocratic and one primarily collegial. As Litwak and Hylton postulated, organizations are induced to cooperate when exchanges of resources are of comparable value. When exchange does not occur, conflict is resolved in the following ways, according to Hicks:

Ways of Resolving Conflict		
Conflict Resolution Approach	Basis	Result
Domination	Large power of one party; other party has little power	Victory of one party; submission of the other
Compromise	Significant power held by each party	Each party gives up something valuable
Integration	Mutual desire to achieve completely satisfactory solution	Both parties completely satisfied

Despite seemingly insurmountable odds, the committee was able to negotiate the larger system (federal funding agency) on its own behalf.

Questions for Discussion

1. What accounts for the committee's success in securing the grant?
2. Could the action of the Council President have been averted? How?
3. In which areas can you identify conflicting value systems?
4. Consider advantages and disadvantages of citizen participation.
5. Did the Council President seem to have the sanction of his board?
Was he empowered to act, even without it, by virtue of his position?
6. What factors contribute to successful inter-organizational cooperation?

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Hicks, Herbert G. The Management of Organizations: A Systems and Human Resources Approach. New York: McGraw-Hill Book Company, 1972.

Huse, Edgar F. & Bowditch, James L. Behavior in Organizations: A Systems Approach to Managing. Reading, Mass.: Addison-Wesley Publishing Company, 1973.

Litwak, Eugene & Hylton, L.F. "Inter-Organizational Analysis: A Hypothesis on Coordinating Agencies," Administrative Science Quarterly, March, 1962.

COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

Even with a rotating office of chairman of the board, the board and its members, if they so desire and are so predisposed, can exercise control over the policy and operations of an operation.

Normally in an organization, control is pragmatically vested in the operating executive. The board and the chairman are the agency for policy determination. Administrative details are rarely referred to the board. These are considered the province of the executive.

Where, however, there is a dominant chairman or group or even an individual on the board who elects to exercise authority, the executive then must assume a secondary role in his administrative responsibilities. In some instances a forceful executive will clash and, dependent upon past experience and support, may be upheld by the board, or lacking that support, will be forced out.

In this instance the council executive deemed it advisable not to assert his will or opinion vis-a-vis the chairman or the board. First, because of his tenuous position and because he was unwilling to tangle with an assertive chairman and finally, because the change in organization gave him additional status.

It is important to note that program implementation can be altered by the policy group which is not considered the focus of such decisions.

Planning and program implementation in this instance succeeded because the planning director of the project had the assertiveness to adopt a posture and position designed to meet the current needs of the project. It is here that administration must acknowledge its debt to the individual. The table of organization established lines of control and responsibility. However, an individual altered those lines and went outside the organization to establish a totally new operation to meet the demands of

the project. In so doing he was able to subvert the control of the board and the executive. This might, in some instances, be a dangerous precedent, but it depends upon the "guts" of those who are looking to see whether the program itself is of more importance than the administrative niceties and personal concerns.

RELATED READINGS

Texts

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Beach, D. S. Personnel: The Management of People at Work, the MacMillan Co., New York, 1965, Chapters 14,16.

Articles

Bennis, W. G. "Leadership Theory and Administrative Behavior: The Problem of Authority," Administrative Science Quarterly Vol. 4 (December, 1969), pp. 259-301.

Schleh, E. C. "Policy - A Vital Force," Advanced Management Journal, Vol. 33, No. 3 (July, 1968) pp. 26-30.

THE CONSULTATION CENTER CONTROVERSY

by William Burian, Ph.D. and Leo Stine, Ph.D.

You are director of a small mental health organization known as The Consultation Center. The organization provides mental health services to clergymen and other professionals such as doctors and lawyers who need to consult with a mental health professional, and who often refer persons needing counseling to the Center.

The Center receives its operating funds from a local fund set aside by philanthropists, from a small fee charged to clients and from community churches. It is an autonomous agency with a Board of Directors made up of college professors, lawyers, ministers and community activist women who have demonstrated an active interest in mental health work. The total budget of the Center during the first year of operation was \$28,800. Although there are other mental health agencies in the community, the Center plays a unique role which is not duplicated by other agencies.

You hold the Master of Social Work degree. As the only member of the agency professional staff, you find yourself functioning as the administrator and as a social work generalist, providing direct casework service and clinical consultation. Within the first five years of the operation of the Center, you find yourself having to make a series of crucial decisions.

The conditions which lead to these decisions are detailed in the following case. You will be asked to make recommendations in each situation to your Board of Directors.

Situation Number 1 - The Center is invited to become part of a Comprehensive Community Mental Health Program, being organized by a local group to function under the State Department of Mental Health. Do you recommend to your Board that the Consultation Center join with other agencies under the Community Mental Health Board? If so, what should be the conditions under which the change is made? What are the legal implications of the Center's involvement with a state-supported agency?

The conditions which lead to Situation Number 1:

The State Legislature, after considerable prodding from persons interested in

the growing problems of mental health, passed a law authorizing communities throughout the state to organize Community Mental Health Boards. These Boards are to survey existing agency services and to prepare a plan for their coordination. The goal is to be a comprehensive system of local mental health services. When such a plan is approved by the State Department of Mental Health, that Department is authorized to provide funds for the expansion of local services to make them more comprehensive. The state is willing to match local funds at the maximum rate of three dollars for every local dollar put into the program, but the state dollars must go into new programs. Since the Center has been in existence less than one year, the local organizer decides that if the Board of the Consultation Center is willing, the Center can be included within the comprehensive plan as an expansion of local programs. Therefore, its support could come largely from state funds under the act. Your budget, (see Document #1) at that time, amounted to approximately \$32,000 of which \$28,800 came from a single fund within the community. You have tried with only limited success to increase the budget sufficiently so that another staff member could be added. Your experience has been that so much of your time is taken up with administration you have too little time left for the mental health work your Center has been established to provide. Therefore, the offer of new money sounds appealing. However, the condition for inclusion within the plan requires a major change in the Center. This raises some important issues.

The Center has been established to work with clergymen on the premise that many people go to them for assistance when they need mental health services. Furthermore, you find that most clergymen are poorly trained to provide even basic counseling service to people with mental health problems. Experience leads you to believe that they need the kind of assistance the Center was established to provide. Furthermore, the clergymen have responded to your overtures and have sought out your help both for training and assistance with cases.

A serious question is raised about state support for an agency which is closely

tied to churches, even though some justification can be claimed since the Center is providing mental health services and counseling. This issue is not insurmountable if the Center's clientele were to be expanded to include consultation with other professional groups, such as lawyers, physicians and perhaps policemen. Doing so would also expand the caseload, and therefore, the expansion of staff and facilities would be crucial. In addition, there is no assurance that professional pride and economic considerations will be such that other professional groups will respond as the clergy have responded.

If the Center were to be included under the new program and the budget expanded, what would happen if the state failed to renew its contract and cut off state support? Could the Center return to its previous status and find other sources of income to make up the deficit?

It is estimated that if the program is reorganized and expanded, the new budget would exceed \$60,000. Fees would increase some but would probably not exceed \$4,000.

What would you recommend and how would you support your recommendation?

Situation Number 2 - The agency board did make the decision to join with the other community agencies in a contract with the Department of Mental Health (see Document #2). The State Department of Mental Health wishes to organize the activities of the Community Mental Health Board. In doing so, the person in charge of state supervision of Community Programs recommends that the Consultation Center be disbanded and the personnel placed in other agencies. The conditions leading up to this situation are developed below. Examine these conditions with the following questions in mind. What alternatives would you identify to your Board? What recommendations would you make to your Board? Assuming your Board wishes to fight for the continued life of the Center, how would you propose that they proceed? How would you respond to the main issues?

The conditions which led to Situation Number 2:

The decision of the Board to join the other agencies resulted in a contract

(see Document #2) with the Community Mental Health Board. Under that contract, the Consultation Center agrees to expand its services to include other professionals, to provide a counseling service to individuals under the limitations of time and space available, to submit budget requests and to provide reports to the Community Mental Health Board. That Board is to be a semi-independent body, organized under the laws of the state, subject to limited housekeeping controls by county government and financed by State Government out of funds provided for the development of Community Mental Health Programs. It will have the power to contract with local agencies for services. (See Exhibit 1 for organizational chart of relationship of Community Mental Health Board to the State Department of Mental Health).

The contract which was signed between the Community Mental Health Board and the Board of the Consultation Center provided that the Consultation Center would:

- (1) Offer mental health consultation to clergymen in their work within the community.
- (2) Provide assistance in referral of persons to any appropriate community resource, and to extend the basis of cooperative working relationships between community resources and clergymen.
- (3) Offer, within the scope of its special characteristics, short term and/or crisis intervention case work treatment to persons referred to the Center and, as the situation indicates, encourage and support such persons in obtaining further help.
- (4) Promote a program of mental health information, education and in-service training for clergymen and within the community.
- (5) Engage in such further activities as may be appropriate to the foregoing state purposes.

It required the Consultation Center Board to "operate in accordance with the administrative and fiscal regulations of the Community Mental Health Board and the State Department of Mental Health - that personnel hired by the Consultation Center be approved by the Community Mental Health Board as a condition of employment and that the Center observe the provisions of the Federal Civil Rights Acts". In return, The Community Mental Health Board agreed to pay a major share of the Center's

operating cost and to "provide psychiatric consultative and related services to the staff". Finally, the contract could be cancelled by either party after giving a 90-day notice in writing.

This contract was approved by both Boards and sent to the State Department of Mental Health. The State Department did not object to the terms and, therefore, both Boards assumed it was acceptable. Furthermore, funds were provided to the Community Mental Health Board to pay the operation cost of the Center in accordance with the provisions of the contract.

The Center Board was encouraged to continue its active interest in its program by the Community Mental Health Board. It continued to approve the expanding budget, to hire additional personnel in accordance with the terms of the agreement and to raise local funds to help support the budget. In two years, the budget had increased to almost \$100,000 of which \$66,900 was requested from state funds (see Document #3).

A new compact between the Community Mental Health Board and all of its constituent agencies including the Consultation Center was signed. This compact designated the Community Board as coordinator of Mental Health Services, emphasized the coordination of services and introduced the concept of a "catchment" area. The compact defined the services to be provided by the Center as follows:

- (1) Mental health consultative services to clergymen and other professional disciplines.
- (2) Short term or crisis case work counseling for individuals.
- (3) Assistance in referral of persons to community agencies from clergymen and other professional disciplines.
- (4) The promotion of a program of mental health information, education and in-service workshops for clergy and other key professional personnel within the community.

The Catchment area concept came from federal legislation designating areas containing 200,000 people serviced by comprehensive mental health programs as eligible to receive federal grants. This concept was difficult to apply to areas

where traditional geographic regions were already being serviced by existing agencies.

Soon after signing this new contract, a controversy arose between the State Director of Community Services of the Mental Health Department and the Community Mental Health Board over approval of a third professional staff member for the Center. The Community Board took the position that: approval of such personnel changes was a local matter; that the Center was an integral part of the community to provide comprehensive mental health services. Furthermore, it had a contract with the Center which could not be disregarded "post facto".

The State Director took the position (see Documents #4 & 5) that he would not approve the increase in the Center's staff, that the Center could not be justified as an independent agency, that it should be dissolved and existing staff members be divided among other agencies and that the Consultation Center Board would have to repay the salary of the disapproved employee. Furthermore, he held up approval of the budget until these actions were taken. No question was raised about the quality of the service performed by the Center.

Thus, the Center found itself in the middle of a controversy it had not made and which it could not control, a controversy over how much independence a community agency could exercise over its affairs when its funding was dependent upon state government agencies. The Center, and its program, was essentially caught in a struggle for control that developed between the State Department and the Community Board. While this struggle was, at times, framed in terms of disagreement about program design, it was clear to all parties in the local community that the central issue was local autonomy vs. state control.

It was soon evident that this controversy was not limited to this one Community Mental Health Board, but that similar controversies were being raised in other communities throughout the state. The local boards looked upon these efforts by the State Director as an attempt to take over their affairs. The State Director saw the power to make such changes as essential to his control over the disbursement of state

funds for which he is responsible. Thus the incident became a major political issue.

The Center Board had not been consulted by the Community Board until the controversy reached the point of urgency. The Center Director was called into a meeting which included the State Director, members of the Community Board and its director. The role and the status of the Center was discussed at length, but the State Director stood firm on his previous position.

The Center Director then had to face a number of issues:

- (1) How would the Center survive without state support?
- (2) How do you simply disband an agency and divide up its personnel without Board action to dispose of property?
- (3) Should the Center Board be advised to support the Community Mental Health Board? If so, what action could it take which would be useful?
- (4) Should the whole controversy be aired in the newspaper or be withheld from the Press?
- (5) Was the State Director "administratively" correct in his assumption of the power to force disbandment of a local contractual agency? How else might he have handled the matter?

Both the Community Mental Health Board and the Center Board decided to challenge the action of the State Director which they considered to be unwarranted. They believed that local conditions should take precedent over state organization plans drawn up without regard for such conditions, and that such independence of action was, in fact, essential to effective service at the community level. Efforts to compromise brought no change in the position of the State Director. (see Documents #6 & 9). It was decided that both Boards should appeal directly to the Governor of the State and that the controversy should not be aired in the community news media until such action had been taken.

Initial appeals to the Governor were handled routinely by his staff and sent to the Director himself for his answer which was then relayed to the local Boards (see Documents #11 & 12). Efforts to bring local legislators into the picture produced only limited results. Finally a visit to the State Capitol and a discussion with a

member of the Governor's staff by the presidents of the two local Boards was decided upon as a last effort to present the local case to the state administration. This visit was successful. The State Director was over-ruled and the status of the Consultation Center as a contractual agency was reaffirmed and clarified. Throughout these efforts, the Center Director kept his Board informed, counseled them to take political action but remained out of the political controversy himself. The staff position in the controversy had been filled and the funds for payment continued to come from the Community Mental Health Board throughout. The Center Director worked closely with the Board President and the Executive Committee of the Center Board.

Situation Number 3 - You have finally settled the problem of continued existence with the State Department. Your agency is due for a limited expansion. The Board of the Center and the Community Mental Health Board asks you to prepare a position paper in which you provide guidelines for future development. What factors should affect its future growth? What recommendations would you make to your Board? What sources would you suggest for possible funding?

CONSULTATION CENTER BUDGET

19XX
PROPOSED

Personnel:

Salary - Director	\$16,000.00	
Car Expense	1,000.00	
Social Security	1,116.00	
Secretary	3,600.00	
Professional Insurance	68.00	
Part-Time Professional Assistance	7,000.00	
Attendance at Professional Meeting	200.00	
Total		\$28,984.00

Facilities and Supplies:

Office Equipment	\$ 700.00	
Rent	1,800.00	
Phone	600.00	
Furnishings	-	
Office Supplies	260.00	
Professional Material	70.00	
(Literature)		
Miscellaneous	100.00	
Annual Meeting	300.00	
Total		<u>\$ 3,830.00</u>

TOTAL		\$32,814.00
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Portion of budget raised:

Civic Fund	\$24,000.00	
Individuals and Churches	6,000.00	
Fees from Clients	2,800.00	
		\$32,800.00

Contract

CONTRACTUAL AGREEMENT BETWEEN THE COUNTY COMMUNITY MENTAL HEALTH SERVICES BOARD
AND THE CONSULTATION CENTER FOR CLERGY

The Consultation Center For Clergy will provide the following services to the area of service covered by the County Community Mental Health Services Board; these services are the essential purposes of the agency.

- (1) To offer mental health consultation to clergymen in their work within the community.
- (2) To provide assistance in referral of persons to any appropriate community resource, and to extend the basis of co-operative working relationships between community resources and clergymen.
- (3) To offer, within the scope of its special characteristics, short term and/or crisis intervention case work treatment to persons referred to the Center and as the situation indicates, encourage and support such persons in obtaining further help.
- (4) To promote a program of mental health information, education and in-service training for clergymen and within the community.
- (5) To engage in such further activities as may be appropriate to the foregoing state purposes.

The Board of Directors of the Consultation Center for Clergy will administer the agency program utilizing the service of an executive. The Consultation Center will operate in accordance with the administrative and fiscal regulations of the County Community Mental Health Services Board and the State Department of Mental Health as it pertains to PA 50 of the Public Acts of 1963, as amended to date.

The County Community Mental Health Services Board will pay the cost of operations of the Consultation Center for Clergy as authorized in the approved budget in relationship to funding under PA 50, as outlined by the State Department of Mental Health.

The office of the County Community Mental Health Services Board will provide psychiatric consultative, and related services to the staff of the Consultation Center for Clergy.

The Consultation Center for Clergy, within the limits of its purposes and resources will utilize personnel practices, procedures, and salary scales acceptable to the Mental Health Board using State civil service standards as a guide.

Personnel employed by the Board of the Center shall have the approval of the Mental Health Board as a condition for employment.

The Consultation Center for Clergy subscribes to the aims, objectives, and principles of Title VI of the Federal Civil Rights Act of 1964 (P.L. 88-352).

The term of this agreement shall begin on July 1, 19XX, and shall remain in force from year to year provided County Community Mental Health Services Board funds have been appropriated, are available, and have been set aside for this purpose, unless cancelled by either party giving ninety (90) days notice in writing to the other party of the intention to cancel.

In the event this agreement shall be inconsistent with any of the rules and regulations of the State Department of Mental Health or the provisions of Act 50, then Act 50 and such rules and regulations shall govern in any area not covered by this Agreement.

COUNTY COMMUNITY MENTAL HEALTH
SERVICES BOARD

By _____

Title _____

Date _____

CONSULTATION CENTER FOR CLERGY

By _____

Title _____

Date _____

Document Number 3

BUDGET - 19XX-19XX

I. PERSONNEL

A. Administrative Director	\$26,568.00
B. Clinical Director	25,942.00
C. Secretary-Bookkeeper	9,400.00
D. Typist-Clerk (part-time)	1,000.00
E. Fringe Benefits (12%)	7,549.20
F. Diagnostic and Consultative Services	<u>4,000.00</u>

TOTAL

\$74,459.20

II. ADMINISTRATIVE

A. Rent	\$ 5,600.00
B. Electricity	600.00
C. Telephone	1,500.00
D. Office Supplies and Postage	1,800.00
E. Travel	1,600.00
F. Publications and Printing	800.00
G. Insurance	380.00
H. Conferences and Conventions	1,200.00
I. Equipment	2,200.00
J. Equipment Maintenance and Rental	1,000.00
K. Facilities Maintenance	500.00
L. Education and Research	2,000.00
M. Community Relations	500.00
N. Miscellaneous	<u>800.00</u>

TOTAL

\$20,480.00

TOTAL BUDGET

\$94,939.20

March 5, 19XX

Perkins P. Peabody, M.D.
Assistant Director
Department of Mental Health
Division of Community Services
Ribau Building
Anywhere, State 00000

Dear Doctor Peabody:

As you will note in the enclosed, revised program narrative, we have indicated the Consultation Center to be a contractual agency rather than Board directed. We have also drawn the organizational chart to indicate its service to both the Comprehensive Center #1 area and the remainder of the county regional service area. We have also enclosed a more detailed description of the C.C. Program which you may find interesting and informative.

The P.A. 50 Board is unable to recognize any rationale for placing this agency in the position of being P.A. 50 Board-directed and bypassing an already existing, legally incorporated body of qualified, interested local people who created this agency prior to local enactment of P.A. 50.

Further, there is and always has been a contract between the Consultation Center Board and the P.A. 50 Board which we do not feel we can or wish to nullify. There was never any local action on the part of the P.A. 50 Board to make the C.C. a Board-directed agency. It is not our present desire to do so.

We have always found the C.C. Board extremely cooperative and imaginative in providing services which further the aims of better community mental health. We also feel that citizen participation in specific community mental health areas is not only desirable but is essential in generating the local support so emphasized in the comprehensive community mental health concept.

Sincerely,

Richard R. Reliable, Chairman
County Community Mental Health
Services Board

Enclosures

cc: Dr. Leo Clark, Chairman, C.C. Board

March 11, 19XX

Richard R. Reliable, D.V.M., Chairman
County Community Mental Health
Services Board
1809 Bloomfield
Somewhere, U.S.A.

Dear Dr. Reliable:

I have reviewed the revised program (as of March 6) for the County Community Mental Health Services Board in which the Comprehensive Community Mental Health Center #1 is detailed. The major deviation from the revised approvable draft which I submitted reflectively back to you centers upon the consultation program. I take no issue with consultation as such; I wholly support the ideas of both case-centered and agency-centered consultation activities. However, my position on the way consultation is carried out is not changed.

First, consultation is an activity of mental health personnel. As such, it is a service performed, but this is not to confuse the term service with the term agency. Since consultation is a general activity and not limited to any type of mental health agency, it is improper to establish a specific agency to "do" consultation as a specialized function.

I have held firmly to a practical principle concerning consultation. Consultation to community agencies is effective as an activity if the consultant is able to assume responsibility for a case which may "sour" after he consults on it. This means the consultant must be able to take over if the case requires it; and in order to do so, he must be a member of the staff of an agency which can provide the services the case demands whenever it demands it. Separate and distinct staffs for consultation programs or agencies set up to do consultation simply cannot fulfill this principle. The Consultation Center clearly has developed into a distinct organization in its own right. It was not so presented when it was originally presented to us for Act 50 approval and funding.

The Consultation Center has grown out of the Consultation Program for Clergy. It was originally a functional activity of the Child Guidance Clinic. You presented justification for moving it out of the Child Guidance Clinic to become a Board-Directed Service. I assumed that this meant, in fact, that it was a central function of the Board.

Your current proposition is that it is an independent agency under a contractual arrangement with the Board. Your budget request of October 5 for the current-year operations presented the consultation service as having two professional employees in continuation request. We made the state budget request and our allocation of the state appropriation based on your request.

It appears from the materials you have submitted that the staff of the Consultation Center has been expanded during the current year. It lists three "directors" against a request for two professional staff positions. Unless everybody at the Center has

taken a cut in pay, the program is overspent and operating beyond requested and approved level. This is a serious administrative error which should be corrected immediately.

I cannot help but think that this kind of error is an example of what happens when an "activity" level function is handled as if it were an "agency". We have not approved the Consultation Center as a contract agency and have no document of contract between the Board and the Consultation Center. Your cover letter of March 5 with your new program statement indicated that the Consultation Center is not a direct function of the Board offices. This leaves question as to whom the Consultation Center staff is responsible and as to how the Board can justify its current level of expenditures.

The reason for establishing the comprehensive community mental health center as a service delivery mechanism is to get away from services being delivered by several separate agencies with separate organizations, separate directorships, separate funding mechanisms, and separate staffs. The Department of Mental Health has recognized that this is a difficult thing to do, but its difficulty is not to be used as a reason for not doing it. If it is to be done, actual steps in the direction of ending the separateness must be taken. Certainly, any steps which rectify, increase or prolong existing separateness are wholly contrary to the goal to be accomplished.

Both Act 50 and the comprehensive community mental health center concept were brought into being in recognition of the problem of separateness as a problem to be solved. Piecemeal services won't get the job done. There still is a profound truth in the historically-valid concept that a servant cannot serve two masters.

On this issue, the maintenance of disparate administrative entities in the structure of the Area Comprehensive Community Mental Health Center #1 must be recognized as less than ideal and perhaps necessary at this time--but it is not valid to consider that the partnership which the Hospital and the Child Guidance Clinic represent is either necessary or appropriate to apply to consultation services. Any clinical staff must be able to serve as consultants to other agencies; there is no justification for separate consulting organizations offering traditional services.

Either of two ways of handling the Consultation Center operation is acceptable to the Department for program approval and funding of consultative services:

1. The consultative service goes on and becomes a Board-directed operation as we agreed in our meeting of September 17;
2. The positions are assigned to other existing program entities within the Comprehensive Community Mental Health Center #1 and the employees responsible to the organization to which they are assigned.

We suggest that the DL Clinic, as part of the Hospital operation, and the Child Guidance Clinic as being appropriate agencies to have the consultant personnel.

Richard R. Reliable

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March 11, 19XX

I hope you can resolve the structural problem of the consultation program soon. I am sure I need not point out that we are quite a way into the current fiscal year for the approval of funding to be so tentative. We really must come to an approved budget with all dispatch. Let me know how you decide to handle the consultation program and let us get on with the budget rewriting.

Sincerely yours,

Perkins P. Peabody, M.D.
Director of Community Services

cc: Mrs. South
Mr. North
Mr. East

March 20, 19XX

Dr. Perkins P. Peabody, Director
Community Services Division
Department of Mental Health
Anywhere, U.S.A. 00000

Dear Dr. Peabody:

Enclosed find a copy of the contract (see Document #2) with the Consultation Center together with the letter written by Dr. Doolittle accompanying its submission to the Department. This and other supporting documents establish the status of the Center as a contractual agency, a non-profit corporation administered by a legally constituted Board of Directors. May we call attention also to previous Department of Mental Health recognition of the Consultation Center as a separate agency through budget approval.

We realize that your many duties and responsibilities make it difficult for you to be knowledgeable of all the details of operation of every PA 50 program. We welcome this opportunity to refresh your memory, since a misunderstanding here may result in most serious consequences related to community support of our mental health services and citizen confidence in the integrity of the PA 50 programs.

Your other suggestions as to program modification or clarification met with Board approval. The criticisms were valid and we appreciate your counsel in helping us to produce a better program statement. However, to arbitrarily alter the status of the Consultation Center would not only make us vulnerable to legal action but also would present a most serious public relations problem as far as the Department of Mental Health and our community is concerned.

We join with you in hoping that this matter may be speedily resolved.

Sincerely yours,

Richard R. Reliable, D.V.M.
Chairman, Community Mental Health
Services Board

RRR/ro
Enclosures

May 17, 19XX

Dr. Perkins P. Peabody
Director of Community Services
Department of Mental Health
Anywhere, U.S.A. 00000

Dear Dr. Peabody:

Enclosed you will find a contract for the Consultation Center for Clergy and the County Mental Health Board.

The Consultation Center for Clergy has been an on-going program for approximately two years and four months. Prior to this direct contract between this agency and our board, this service was under the sponsorship of the Child Guidance Clinic. The agency itself has been making an impact on this community and the surrounding areas in the field of mental health consultations to the clergy.

It was the feeling of the Mental Health Services Board that the program of this agency was strong enough to deserve direct agency status. Therefore, after several meetings with the board of this agency, we resolved to support this agency under direct contract. We feel, as a board, that this contract is inclusive enough to allow for sound programming.

One area in which we are asking your opinion is in regard to the termination clause which at the present time is set at ninety (90) days. We feel that this should be longer, if it meets with your approval. In the budget, which we will be forwarding to your office, this agency will be brought out of the Child Guidance Clinic figures, and will stand as a separate budget item.

We feel that this contract will greatly strengthen mental health programs in our area. The County Community Mental Health Services Board unanimously approved this contract at its regular monthly meeting held on May 17.

Sincerely yours,

A. J. Doolittle, M.D.
Psychiatrist-Director

Document Number 8

The following are notes made on a meeting held March 28 at the local Holiday Inn between the County Mental Health Board members and Dr. Perkins Peabody, Director of the Community Services Division, Department of Mental Health. The meeting covered a number of issues of common concern. Notes on the discussion of the Consultation Center question are included below.

Essentially, Dr. Peabody's position has not changed at all. According to an agreement made at the State Capitol between the Department, Mr. Dally, Mrs. Webb, and Dr. Angora, this agency was board directed and could not, under any circumstances, be otherwise. When told that the Agency did not have any awareness of this or were there any local minutes on the transaction, there was very little response. Asked what to do about the contract, he replied that, "he figured the September letter nullified the contract, if there was indeed a legitimate contract at all." When asked about the Citizen's Board and what part it would have, his comment was that it would serve only as an advisory capacity and again this was something he could not spell out for me. He may have received some feedback from the letter that was written to the governor by Dr. Clark and Reverend Priest because in my absence from the room for a moment he made reference to this.

He began on the business of our Agency being a service or an activity rather than an agency as he had done in the letter. We attempted to correct him on this and then he said that we were a service, not "a free-standing agency" and that was not acceptable to him because we could not follow through. I pointed out to him that because of our working relationships with the other existing mental health units our service could carry through in any degree necessary within the scope of its community relationships. He then went back to the notion of being a free-standing unit and that all units should provide consultation, education, etc., but that there were no grounds on which he could or would support the Consultation Center as part of the total complex.

He suggested the following alternatives:

- (1) That the Agency "become Board directed" in the fullest sense of the word which would mean that the local Community Mental Health Board would be the Board of Directors for our Agency and that we would not only be ultimately but rather completely under the auspices of the Board.
- (2) The Consultation Center could become a part of the comprehensive program Number One. This, he thought, might be a good idea. The local Mental Health Board has more or less taken a position that they did not wish to minister programs as such, rather to be a coordinating body. Just what it would mean to be a part of the first comprehensive center is not clear and could not be clarified at this point in time.

- (3) Another option was suggested as remotely possible, that would be that this Agency become the nucleus for the second comprehensive center on the southern side of the state. This second center is supposed to be on paper and in the planning stages at this time, although I doubt if it is.
- (4) But if the Agency is not willing to do any of the above three that we simply cannot be carried as a part of the State mental health program and be eligible for matching funds through them. I asked him if there were funds available to continue through the rest of this fiscal year; and with a rather struggling look, he said it would be remotely possible that it was highly likely, especially if we were to agree to going into one or the other above-three programs next year.

Dr. Peabody was not impressed with the Citizen's Board of the community support and approval of this Agency; he simply insisted that it should not be considered a high priority agency despite the fact it is doing high priority work according to the mental health manual, but this did not seem to be his inclination; and, therefore, because we were not in his mind, high priority, the funding possibilities were very slight.

No decisions were reached at that point in time. I asked Dr. Peabody to write again his analysis of our situation and put on paper his alternative for us to deal with. The matter was left open simply because of Peabody's position and the fact that at this point we must now return to our board for further guidance as to program.

I think if our board submits to this and becomes an "advisor board" we still have legal complications in regards to the ownership of the real property with any agency which, according to my understanding of the desired relationship on the State Government's part, would automatically become their property. This is a matter of a few thousand dollars, but it is important to consider and clarify.

Mr. Peabody gave us one other alternative: that was that we become a free-standing agency, operate on our own without the help or benefit of the Department of Mental Health or Public Act 50. This he suggested not as an anticipated likelihood, but more or less as a threat to come into line.

I do not think our board should move hurriedly on this. I think that when this small agency gives up its right to govern itself, then it is simply a matter of time until the same phenomenon happens to other agencies who are dependent on the Department for their basic stability. The local board must consider this very seriously and rather soon.

There was another option left to us by Dr. Peabody. It was that this board and agency which he still insists calling a function or activity disband. The professional members of the agency will be forced out to other of the existing standing agencies within the community. These include Child Guidance, State Hospital, or the Adult Psychiatric Clinic.

Under no circumstances am I ready to accept the above alternative for myself as an individual, although I do not speak for the other staff persons.

We are facing some very hard decisions but I suspect that they shall have to be faced, dealt with, and decided within a matter of two weeks or so.

April 1, 19XX

Richard R. Reliable, D.V.M., Chairman
County Community Mental Health Services Board
1809 Bloomfield
Somewhere, U.S.A. 00000

Dear Dr. Reliable:

Let me recapitulate several points of our discussion at KCO on March 28, relative to the possibilities for the Consultation Center. We observed that the Consultation Center has no administrative structure whereby it handles its own payroll completely. In some ways it has functioned as an agency in its own right, and in other (e.g., the Community Mental Health Services Board makes certain payments directly to staff of the Consultation Center) it functions as if it were an integral function or direct operation of the Community Mental Health Services Board.

We find at this time that the Consultation Center has expanded staff without the formal approval of the Community Mental Health Services Board, and the Board has not obtained program and budget approval for such expansion from the Department of Mental Health. The Department of Mental Health could not (I cannot) give approval to the current level of operation of the Consultation Center since, as either a board-directed service or a "free-standing" contractual agency, its improvement or expansion has no state allocation priority which would justify its funding as improvement.

If the Consultation Center is considered (and in fact becomes) an integral part of your Comprehensive Community Mental Health Center #1, it would benefit from the high priority given to comprehensive community mental health centers. This would require that the staff of the Consultation Center become staff of the Comprehensive Community Mental Health Center. I had suggested that the staff become administratively a part of the B & D Clinic or that it be divided between B & D and the Child Guidance Clinic. Either way, it has no continuity as an entity in its own right and its Board of Directors would have no further *raison d'etre*, i.e., it would become board with nothing to direct.

You may also recall that for a moment we dwelt on the idea of the Consultation Center staff (since it has functioned as a quasi-clinic with direct service cases) being retrieved at a later date to form the nidus of a professional staff for a second comprehensive community mental health center when the time is ripe.

Richard R. Reliable

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April 1, 19XX

In view of the fact, and the fact that the board members of the Consultation Center have had a spontaneous and generous interest in local mental health program development, I suggest that you may wish to invite their support of all of the programs of the Community Mental Health Services Board. From time to time they may be of great value in developing local citizen support for newly developing programs.

Please let the Department know when we will be able to confer with Mr. Moss to complete the budgeting for this year. The decision as to the definitive handling of the Consultation Center--where it is to fit structurally and how its funding is to be handled--appears to be the only incomplete aspect of current year programming.

Sincerely,

Perkins P. Peabody, M.D.
Director of Community Services

April 9, 19XX

Dr. Perkins P. Peabody, Director
Community Services Division
Department of Mental Health
Anywhere, U.S.A. 00000

Dear Dr. Peabody:

Representatives of the Consultation Center Board of Directors and staff have indicated their willingness to accept an option you proposed in our meeting of March 28. The same alternative was suggested in your letter of April 1, and we hope it will serve to resolve our present difficulties.

We are prepared to recommend to both the Consultation Center Board and the County Community Mental Health Services Board that the Consultation Center staff become a part of Comprehensive Center I for the present, with the understanding that at some appropriate future date these professionals will serve as a nidus in the development of the second comprehensive community mental health center. It is deemed especially important that this professional staff be kept intact to continue the community-oriented work which is so well-received and so valued locally. With this assurance, the Consultation Center Board would agree to relinquish its supervision over the program which would place the staff administratively under Comprehensive Center I and under the supervision of the Co-Directors, Drs. Friend and Crane. The Consultation Center Board, which has a lease on quarters and owns the equipment, has offered their use for the continuation of services and would plan to continue financing at approximately \$28,000 a year if the County Community Mental Health Services Board will fund the staff services.

Please let us know if this is agreeable to you so that we may present it to our Boards and send Mr. Moss to complete the budgeting.

Sincerely yours,

Richard R. Reliable, D.V.M.
Chairman, County Community Mental
Health Services Board

109 South Lauderdale
Somewhere, U.S.A. 00000
March 15, 19XX

Honorable Harry Lewis
Governor
State Capitol
Anywhere, State 00000

Dear Governor Lewis:

I am the Chairman of a small group of about 15 local citizens who have been serving as members of the Board of the Consultation Center, a community mental health agency. This agency began about five years ago as the Consultation Center for Clergy, a private agency providing educational and consultative mental health services to the clergymen in our community. At that time, we also provided limited case counseling services to some individuals referred to the agency by the clergy. About 45 clergymen used our services.

At the time that the County Community Mental Health Program was organized in our county, we were approached by some of the individuals then planning that Program to join with them in helping to provide a comprehensive service in the area. After considerable discussion, the Board of the Clergy Consultation Center agreed to the Center's being included in plans which were then being submitted to the State Capitol for approval. In order to provide for more efficient administration, we were included as related to the Child Guidance Clinic. We, therefore, signed a contract with that Clinic to provide the services of our staff in return for financial assistance from the Public Act 50 state program which was to be administered through the Community Mental Health Services Board. The first Director of that Board, a Dr. Doolittle, was unhappy with our association with the Child Guidance Clinic and requested that we sign a separate contract with the Board. Again, our Board agreed to do so, and the contract was signed by both parties. This contract has a 90-day clause should either party wish to sever the relationship. We have assumed that this contract was agreeable with the state mental health officials, since we were given state financial assistance for our continued operation.

Now, we are being told by Dr. Perkins P. Peabody, the Director of Community Services of the Department of Mental Health, that we must dissolve the agency and eliminate the local Consultation Center Board in order to get any continued support for this program. This is not being done to satisfy the wishes of the Community Mental Health Services Board, but rather to satisfy Dr. Peabody. We have cooperated with the local Mental Health Board and have had excellent

March 15, 19XX

relations with them. We have greatly expanded our services as staff became available so that we are now providing mental health services to a large number of community agencies and professional groups in addition to the clergy. Our Board is composed of a number of outstanding local citizens who have not only given of their time and money, but also have served as an important liaison with the groups being served. Thus, the Board has contained ministers, lawyers, medical doctors, professors, psychological personnel in the local school system, the Chaplain of the local hospital, and others.

The most difficult part of this problem has been that Dr. Peabody has acted quite arbitrarily. He has not attempted to find out about our agency or its services. He displays a complete ignorance of it in his communications with the local Community Mental Health Services Board. He has simply ordered its dissolution without a hearing. He is operating on his own premises without showing a willingness to listen to evidence which might show them to be questionable.

This kind of arbitrary action cannot help but have a serious effect on the activities of our local mental health program, as well as our attitudes toward state administrative agencies. We realize that we cannot win this fight, since we can no longer support these services entirely out of community funds; although we have continued to raise local funds to help support the program. In these times when local citizens are raising the spectre of arbitrary action on the part of state officials, the impact becomes much greater.

I am not writing in behalf of either local Board. I am simply reporting a situation to you which I hope can be corrected before it is too late. I hope that you will lend the assistance of your office in a much more careful consideration of this matter than it has received from Dr. Peabody.

Sincerely,

Leo Clark

cc: Senator Sam Smith

April 8, 19XX

Mr. Leo C. Clark
109 South Lauderdale
Somewhere, U.S.A. 00000

Dear Mr. Clark:

This is in response to your letter of March 15, regarding the Consultation Center and its relationship to the County Community Mental Health Services Board and theirs to the Department of Mental Health. Our understanding is that the Consultation Center is an outgrowth of a former subagency function of the Child Guidance Clinic, which was known as the Consultation Center for Clergy. As such, it represented an activity of the Child Guidance Clinic at the time the Child Guidance Clinic came under contract with the County Community Mental Health Services Board.

It is our further understanding that the Consultation Center for Clergy evolved into the Consultation Center which made an independent contract with the County Community Mental Health Services Board. Its continued function was approved for funding as an independent agency in contrast with the Board; but no expansion of its staff of three persons, and no increase in its funding was approved. The Department of Mental Health informs us that new employees have been added, functions expanded and increased expenditures reported. But approval for such expansion from the Department of Mental Health, through the County Community Mental Health Services Board, was not given, and, thus, the original budget of the Consultation Center under the Act 50 program is seriously overspent.

We also understand that the Department of Mental Health has been in prolonged negotiation with the County Community Mental Health Services Board in a mutual attempt to effect an approvable organization of services for the area within the concept of the comprehensive community mental health center. We understand that consultation is an integral service activity of such a center and that the approval of the overall program by the Department of Mental Health has called for assimilation of the consultative function into the overall service functions of the mental health center being developed.

The Department of Mental Health has informed us that integral elements of comprehensive mental health centers have had first priority for improvement funding for the current year, but that appropriations for the current year did not allow improvement funding for lower-priority, free-standing consultation services such as the Consultation Center represents. It appears that the problem of the fiscal difficulties of the Consultation Center could be resolved within the development of the comprehensive community mental health center. Without its moving into assimilation in the center, there is no mechanism available to the Department of Mental Health to help resolve its financial problems.

Mr. Leo C. Clark

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April 8, 19XX

I hope this will assist you in resolving what appears at this juncture to be a misunderstanding as to responsibility and accountability. If I can be of any further assistance, please be certain to contact me. Also, keep up the good work.

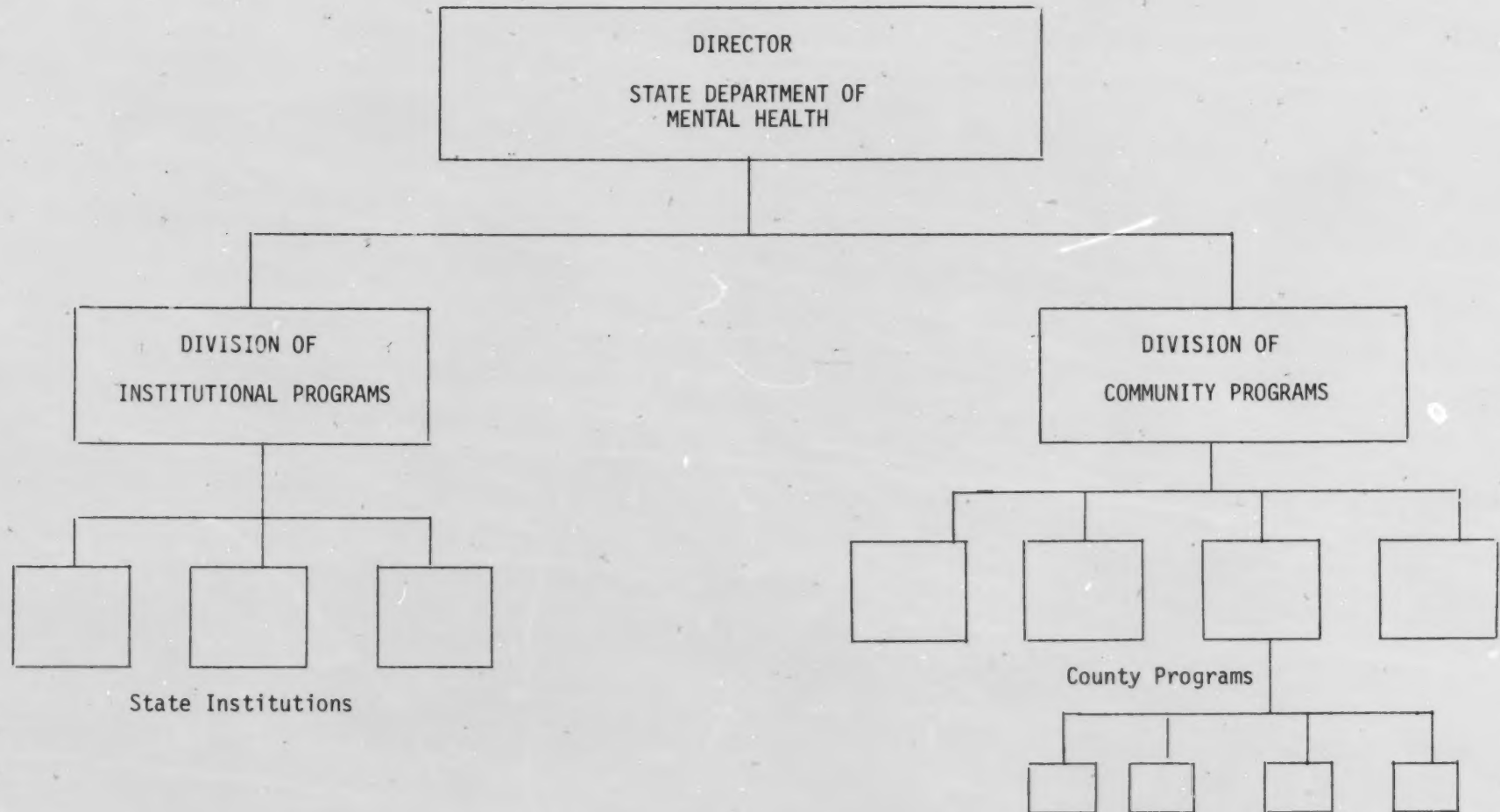
Sincerely,

Harry Lewis
Governor

It should be noted that this letter from the Governor represented the position of the State Director of Community Mental Health Services. In preparing it, the Governor's staff simply asked the State Director to prepare an answer to be sent to the Chairman of the Board of the Consultation Center. Subsequent to that, the Board Chairman and Pastor Priest called on a member of the Governor's staff who was known by the Chairman. The staff member listened to their presentation and promised a much more thorough investigation. It was that investigation which lead to a change of policy.

EXHIBIT ONE

ORGANIZATIONAL RELATIONSHIP OF DEPARTMENT OF MENTAL HEALTH
AND COMMUNITY PROGRAMS



COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by William Burian, Ph.D. and Leo Stine, Ph.D.

Situation 1:

1. What are the consequences of considering domain expansion of this agency (see James Thompson, Organization and Action as reference.)
2. How is domain expansion a means of managing uncertainty in this situation?
3. What considerations with regard to the question of the separation of church and state are involved and why?
4. How would the action of becoming part of the Mental Health Board effect the goal setting of the Consultation Center?
5. What is the probability of returning to the voluntary funding base once the move to a public funding is made? How could the voluntary funding base be maintained while making use of the public funding source?
6. What considerations should be made with regard to the mixing of voluntary and public funding?

Situation 2:

1. What environmental scanning is suggested by the particular pattern of inter-organization relations?
2. Given the environmental scanning, what types of alliances are reasonable for the Consultation Center and the Mental Health Board?
3. How does the mixture of political, social and technical rationality play in this situation? (see Paul Diesing, Reason and Society)
4. What hints are there in the situation description about the existence of a larger context of inter-organizational conflict?
5. What types of power struggle may be going on between the State and Community Mental Health Board?
6. What are the ramifications of broadening the conflict by airing it in the newspapers?
7. How do existing systems of political and social relations play into resolution of the conflict?

COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

The Romans had an expression for it, qui pacit, facit, "He who pays makes it happen."

The siren lure of money has been used to bait the hook in any number of private and public programs and, as a result, the agency and program have been "had."

Here is an organization which established a program which was meaningful for the community in an attempt to develop a mental health program to which clergymen and professionals such as doctors and lawyers could send persons in order to take care of their needs or to be referred to other agencies or programs. It is a special interest program which appeared to be doing its job well. However, as in many such instances, the funding was minimal and the job which could be done with additional staff and additional financing could have been that much better. The question is then, "From what sources"? Obviously, the answer is, "From the government."

The state and federal governments have been involved in mental health programs and other social service programs, funding them and expanding their operations for the community. But it is not to be expected that the funding agency will merely shovel out dollars without some response from the agency which would require fiscal responsibility or adherence to professional and administrative guidelines and regulations.

In many ways, this is the kind of classic example of the camel's nose in the Arab's tent. By slow degrees, the agency has expanded, become more viable, and forgotten that it is not independent of state funding. Then, when the funding agency says "dance," it behooves the agency to move in accordance with the rhythm

designated by the funding agency.

In this particular instance, the agency has gotten a reprieve from state control. But it stands to reason that no state funding agency will stand aside and allow a group to be outside the administrative and fiscal reporting responsibilities. Moreover, an agency must measure up to certain standards which the state will apply to all in order to have uniformity. While the agency may have won in this instance, it will be anticipated that the eventual control will be exercised by the state director because it will not be admissible for one agency to be outside the purview of the regulations while others are conforming.

The agency must then either accommodate itself to the requirements of the funding groups' regulations, or must withdraw, and in so doing, reduce its program and its staffing in accordance with the shrunken funding.

Related Readings

Louvierr, V., "Better Management in Government," Nations Business, November, 1974, p. 72.

Mechanic, David, Mental Health and Social Policy, Prentice Hall, Englewood Cliffs, N.J., 1969.

Millett, John David, Government and Public Administration; The Quest for Responsible Performance, McGraw-Hill, N.Y., 1959.

Linowes, D.F., "More Effective Government With Less Dollars," Vital Speeches, August 1, 1974, pp. 632-5.

STEERING A GRANT PROPOSAL THROUGH STATE AND FEDERAL BUREAUCRACIES

by Arthur Rosenfeld M.S.W.
(as told by Rick Baron)

This is a study of an attempt to process a grant proposal through both the state and federal bureaucracies, presented by the staff person with primary responsibility for developing and administering the proposal.

Background

Horizon House Institute (HHI) is a private, non-profit, research, evaluation and public education agency under yearly renewable contract with the State Department of Public Welfare. It is an outgrowth of a long established mental health agency providing aftercare facilities for the mentally ill, the mentally retarded, and the substance addicted. The Institute was formed to provide a center for consideration of broad areas of human service planning and policy issues. The Institute's recognized area of expertise (and main service to the state) is in the field of mental health and mental retardation and the development and evaluation of effective and compassionate support for mental health and mental retardation programs.

Issue: Examination of community response to the development of community care systems and the narrowing role of state hospitals.

PCHIP

Through previous contacts, the Institute had a relationship with the Public Committee for the Humanities in Pennsylvania, an affiliate of the National Endowment for the Humanities. PCHIP is interested in funding projects which involve "academic humanists" (college and university instructors of history, literature, philosophy, ethics, anthropology, political theory) with the general public in matters of social policy. Their focus is to bring the values of academic humanists to the consideration of public policy makers.

Proposal

The Institute approached PCHIP with a proposal for a statewide public education project on MH/MR services. The issue posed was the future of mental health policy, and specifically, the public response to the issue of community care.

PCHIP funding patterns included large grants which must be matched (50%) by a third party (the grantee could not put up its own funds). HHI asked the State Department of Public Welfare to provide the matching funds (in addition to current obligations to the Institute). The initial response was positive, promising but not committing funds.

The proposal to PCHIP was for a fifteen month project as follows:

(a) First phase--a series of evening forums on MH/MR issues in eight communities across the state bringing together academic humanists, professionals, consumers, advocacy groups, businessmen, etc.

(1) The forums would include films and/or presentations by academic humanists relating to the history of MH/MR services, legal rights of consumers, legal rights of communities, etc., followed by audience discussion.

(2) All sessions would be filmed, videotaped, and made into an hour film to be broadcast over the seven public TV networks in the state with a follow-up-call-in format.

(b) Second phase: Second round of community hearings following the TV show.

(c) Third phase: Evaluation instrument. (The proposal did not include funds for packaging and distribution of film and materials, but this was also a possibility for the future.)

(d) Total Grant: \$172,000.

(1) one-half from Pa. DPW

(2) one-half from PCHIP

Letters of support were obtained from a wide variety of sources, including the Public TV Network.

Contract Negotiations

The proposal was submitted on the last possible date of the funding period, May 5, 1975. A response was expected from PCHIP by the end of May (allowing the project to begin by July 1). Because PCHIP received many proposals, HHI's was not acted upon until the end of June. (This was the second largest proposal ever submitted to PCHIP). The proposal was accepted by PCHIP with a proviso that minimal program conditions be stated further in the proposal, including:

- (a) Provisions for two academic humanists at each meeting.
- (b) A sketch of what the sessions would be like.

The financial conditions, however, proved to be increasingly complex, and led to a series of bureaucratic maneuvers among the several state and federal agencies involved.

(a) PCHIP did not want to commit its 50% share at the outset -- it wanted to provide partial support, with the remainder after an evaluation conference in six months (i.e., two phases).

(b) PCHIP insisted on a evaluation conference at the end of the project.

Upon receiving this tentative acceptance, the Institute contacted the DPW for its share under the previous understanding. At that point, the Institute was in the process of negotiating its yearly contract with DPW. The DPW said it could not grant funds for the project over a fifteen month period because it is prohibited from entering into contracts for more than one fiscal year at a time, and that the project would have to be funded in two periods.

By this time, it became clear that the project would not start as intended on July 1. Therefore, HHI proposed starting October 1 and holding the first evaluation (required by PCHIP) after the first round of community meetings in May. Thus, the second phase could begin July 1, which would put it into the next fiscal year for both DPW and PCHIP. The state could then write two checks, one in each fiscal year.

At the same time, HHI suggested that the state funds be included in its yearly allocation and earmarked for the public education project. The costs of the film production were included in the first year proposal. PCHIP gave approval to this plan.

Finally, DPW submitted the plan for routine scrutiny to the State Budget Office for formal approval. Here the process became extremely thorny. PCHIP regulations stated that matching funds must be from a third party in form of check to the National Endowment for Humanities (PCHIP was at that time merely a conduit--receiving funds, sending them to NEH for doubling, and sending checks to grantees). DPW said that the State was not permitted to write a check to a federal agency. PCHIP insisted that the conditions of the project required a check in only one form.

For a three week period, the Institute wrestled with these complicated and time-consuming bureaucratic procedures. The state wanted to write a check to HHI to be forwarded to NEH, but this was forbidden, as the funds would then legally not be third party funds.

Coincidentally, during this time, PCHIP established itself as a new legal entity which could legally receive checks and forward them to NEH. Thus, the state check could be made out to PCHIP (The state was, therefore, not writing a check to the federal government).

Thus, HHI developed a procedure to bill the state for project expenses and have the state send these funds to PCHIP (on a quarterly basis). These bills would accumulate over three month periods and be sent to the state for payment to PCHIP. (The Institute's operating expenses were on a monthly basis).

By late October, all parties had agreed to the terms of the contract (including one fiscal officer of the Office of Mental Health in the state). However, in early November, the Governor's office raised its first objection. Could the state legally write a check to PCHIP, affiliated with a federal agency, and without its

own contract with the state? The Governor's office asked the state treasurer to rule on the situation. The treasurer's office ruled that because the state had no contract with PCHIP, it could not write a check, and sent the matter back to the fiscal officers of MH and DPW for resolution. In early November, the Treasury Department reversed its ruling on the basis of meetings with all parties. A letter of understanding detailing all the agreements among the various agencies was drafted and sent to all parties, including the State Treasurer's office.

During all this time , (five months), no one at any level had raised any substantive questions about the project (aims, program, salary, etc.). The entire issue had been how to get the federal and state bureaucracies to exchange money.

In mid-November, the Governor's office finally signed the contract.

The project had been "gestating" for about a year until final authorization was given for hiring staff. Could these problems have been foreseen? Perhaps an early conference with state fiscal officers could have predicted some problems, but generally the state does not tend to deal with fiscal policies ahead of time -- only when there is an emergency.

The Director of the Institute and the Administrator of this program assumed key roles during the entire negotiation process. There was continuous rewriting of budgets and program plans. They were "middlemen" in the negotiations among the various agencies, and they were called on to interpret complex legal and fiscal matters. Patience and perseverance were the main qualities which enabled the project to succeed in being funded.

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Richard Estes

Aside from the purely fiscal issues described in this case, what are the more critical political issues which the various State and Federal agencies are attempting to resolve through the layers of bureaucratic red tape and procedural entanglements? What fundamental principles governing State-Federal relations are at stake and how are they reflected in the States' decision to prohibit the transfer of State funds to federal or federally affiliated agencies? How were these principles translated into daily state fiscal policies as the proposal sought approval at each level of government?

What must the public social service administrator understand about these critical State-Federal government principles if they are to function effectively in facilitating intergovernmental fiscal arrangements? To what extent are the fiscal and constitutional problems here characteristic of similar problems at the city and county levels?

To what extent might some of the most critical coordinating problems have been avoided, or at least minimized, through more adequate anticipatory planning on the part of the HHI and the PCHIP staff? What does the filing date of this application suggest about the proposed overall planning process and in what way (s), if any, do you feel the late filing date impacted negatively on the award process?

The administrator is obviously familiar with and sensitive to the complex workings of government at various levels. What special knowledge or expertise do you feel the public administrator needs to insure successful results in negotiating agreements with governmental agencies, albeit such agreements may occur only after a rather tedious and time consuming process? Where might the administrator best acquire these skills and, if necessary, what knowledge or skills in other areas must be postponed while acquiring these more "political" skills?

Unlike State agencies, Federal granting bodies can approve contractual awards for a period in excess of one fiscal year, albeit such awards are contingent on satisfactory performance by the contractee during the preceding program year. What do you understand to be at the basis of PCHIP's decision to provide funding on a more time limited basis and, only then, after an interim evaluation of the project's efforts? What purpose (s) does this conditional contract serve for PCHIP? For HHI? What alternative response to these conditions might the HHI staff have made in its effort to win a longer term commitment from the PCHIP?

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COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

The exchange or payment of money involved the control process of the administrative organization. Rules, procedures and legalities require that the passage of money be documented so that the correctness of the payment is authenticated and individual responsibility vitiated.

The conflict between program concept and implementation and program administration is demonstrated here.

The pre-audit functions put into play the many administrative constraints to identify and verify that the money is properly expended, that the legalities are followed and more importantly, that on post-audit the expenditures will not be ruled improper, illegal and worst of all, a reimbursement required from funds of the agency to repay for the "improper" expenditure.

The pre-audit operation as an accounting device provides the administrator with a declaratory judgment which is similar in law. It is a determination that the proper procedures and legalities have been followed and the program can then proceed without further question. The administrator's concern is with providing services in accordance with the provisions of the agency's charge. Pre-audit and financial controls are considered by the administrator a constraint on the agency and its effectiveness to perform its services.

Fiscal accountability by the administrator to the program looms as large as program responsibility. Each plays a responsible role in the program. This is partially true when there are levels of financial resources so that the agency is responsible to the local or state funding groups which in turn may be responsible in whole or in part to the federal or other levels of government.

Under these constraints, each is concerned that on post-audit the action would not be ruled improper or illegal.

The difficulties are compounded by the complexities of the layers of administrative concern, each level or agency insuring that its past actions are correct and double checking on the others. The result is another cordon of administrative personnel concerned with fiscal controls which obviate fiscal responsibility to the agency and to the individuals who are exercising those administrative responsibilities.

What is of interest and of concern to us here is that this large wedge of administrative personnel is becoming almost as large as those who are the program administrators.

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THE MERGER PROCESS

by Arthur Rosenfeld M.S.W.

Introduction

This case deals with the planning and implementation of a merger between two child care agencies. This study will focus on the role of a third party in the process--the social planning agency. The case will illustrate a variety of planning roles and indicate how the planner dealt with a myriad of difficult administrative problems.

Background

The agencies involved in this study are the A.B.C. Day Care Center and the Neighborhood Children's House (fictitious names). Both are affiliated with a sectarian (Jewish) federation and receive the bulk of their support through the United Way.

Both agencies were founded early in the 20th century as primarily custodial centers for children of working mothers in poor neighborhoods. Food and shelter were the basic services provided.

Through the years, each agency developed in significantly different ways. The Neighborhood Children's House (NCH) built a strong educational component into its basic service by utilizing skilled professional staff. Although the sectarian population of the surrounding neighborhood declined, the agency continued to provide its services in the neighborhood on a non-sectarian basis. The agency has remained small, serving some fifty children.

The ABC Day Care Center was also founded primarily as a neighborhood shelter for children of immigrant parents. However, as the sectarian population of the agency declined, the agency followed the bulk of its constituents to another area of the city. In its new location, the agency received enough community support to secure a new facility, and expand its services to its present caseload of about 175 children.

In 1968, the ABC Center began to explore the possibilities of establishing a new service, group care for school age children. The presentation of this idea to the Planning Department of Federation resulted in a complete re-examination of current day care services (the social planning agency). The Federation Planning Department felt that the present competitive situation (two agencies offering similar services) has for years resulted in "embarrassing differences in policy, salary levels, personnel practices, tensions around geographic responsibility and the absence of a total community viewpoint."

Federation's Planning Committee concluded:

No real progress in day care on a community-wide basis will be made until there is one agency with community-wide planning responsibilities.

Early the next year, Federation called a planning meeting with the current and past Presidents of both day care agencies, at which time Federation's point of view was spelled out, in the form of long-range objectives as follows:

1. The increasing importance and value of day-care services was recognized.
2. Planning must be done on community-wide basis.
3. One agency would insure the highest possible quality of care:
 - (a) sharing of staff, resources, experience, skills
 - (b) uniform policies and standards of care
 - (c) more effective interpretation of community needs
 - (d) more effective coordination with other fields of service.

Other factors which influenced Federation to suggest development of a single agency were:

1. Pressure from the United Way to effect the greatest possible coordinated planning in all fields of service.
2. The increasing availability of Federal funds for day care. A unified community approach could mean a greater chance to obtain federal funds for new services.
3. The pending retirement of the Director of NCH.

The agency responses to these long-range objectives were mixed with doubts and concerns:

1. They argued against one community viewpoint, feeling that the geographic areas served represent different communities with different needs.
2. They presented evidence that mergers generally do not save money, but are more costly.
3. They feared that merger would produce an agency in which the large agency dominated the small one.

These concerns set the groundwork for a long and intense debate over the merits of merger. The Federation Planning Department became the focal point for the merger discussions, and the roles played by the planner proved to be crucial in guiding the merger process to its conclusion.

THE MERGER PROCESS

1. Initial Resistance

The long range objectives of Federation pointing toward a single agency were met with strong resistance, particularly NCH. Mrs. K., Executive Director of NCH, saw merger as a critical evaluation of her long years of service, and the Board saw merger as a threat to its existence. It was generally assumed that the NCH would be swallowed up in the merger process. In addition, the agency felt many people assumed it was a low-status agency because of its location in a low-status neighborhood.

The Board of NCH did, however, recognize the need for community planning in the day care field. It proposed that as a first step toward planning, an "umbrella" agency or association of the day care centers be established, which would act as a planning agency in the day care field, but would assume the autonomy of the current agencies. The Board was also anxious to pursue hiring a new Executive and to prepare for a smooth transition of authority after the retirement of Mrs. K.

The ABC Day Care Center, on the other hand, supported merger. However, that

Board was eager to expand its services and explore opportunities for federal funding. While supporting long-range planning and merger, the agency did not want the merger process to impede its development.

2. Policy Alternatives

Federation planners were thus confronted with the following alternatives:

- (a) Use pressure (budgeting power) to force NCH to accept merger
- (b) Abandon merger plans for time being--at least until retirement of Mrs. K.
- (c) Proceed with day care planning without NCH, recognizing ABC Center as the community agency, and aiming for expanded services.
- (d) Appeal to other sectors of the community (other agencies, boards, etc.) to urge NCH to change its mind.
- (e) Intensify joint meetings between agencies, while continually exposing NCH to other viewpoints.

The first four alternatives were rejected. It was felt that a show of power by Federation was not wise for many reasons. The agency Boards were autonomous and capable of making valid decisions. Abandoning merger plans temporarily might make merger more difficult in the future, especially if a new Director were hired by NCH; planning only with ABC would be divisive; appealing to other agencies would bring the dispute into the open and might be counter-productive. Thus, it was decided to intensify the merger discussions.

3. Informal Discussion: Progress

The first step was a series of informal meetings between the Planning Director and his key lay leaders with each agency director and their key leaders. The purposes were to clarify the agency positions regarding merger, discuss their concerns and expose each agency to concerns of the other. Meeting separately with each agency, the Planning Director assumed the key role of information processor and negotiator.

Each agency expressed its fears and concerns--NCH that it would be "swallowed up" in a merger and that service to the neighborhood might suffer; ABC that many

questions regarding structure, budget, leadership, etc. might prove difficult. Federation assured NCH that it had "no desire to destroy" NCH, and would not permit the elimination of any service in a neighborhood where it was needed. Similarly, ABC was assured that actual merger details would be worked out jointly with input from each agency.

After several months of such informal discussions, there was a noticeable change in the attitude of NCH toward merger. There was a "realization on the part of NCH that merger was bound to come, although they had many concerns about it". They still favored the "umbrella concept" (an overall director, supervising several branches), but they "didn't seem to imply the need for continuing independent boards". In addition, the agency was eager to hire a new director and wanted this person involved in the discussions.

Both agencies pointed out that neither agency board had been officially appraised of the objective of merger, nor was there any official authorization to proceed with this matter. It was therefore decided that the next step should be the official presentation of the concept of merger as a desired community goal to each agency board by the chairman of Federation's Merger Committee (a layman).

4. A Step Backwards

The Director of Federation was invited to present the merger proposal to the NCH Board. He asked the Board to approve "the establishment of a joint committee of the two agencies and Federation, to work out blueprints for merger details, by-laws, and a program that will be mutually acceptable to the two agencies".

The Board wanted to improve the quality of service, but wanted reassurances that the agency would not be neglected. It suggested and approved setting up a "joint committee to study and consider day care needs on a city-wide basis," and a group of board members was chosen to represent the agency in this study.

The interpretation of this meeting proceeded to be a major source of conflict

which seriously threatened the future of merger discussions.

The NCH Board did not act on Federation's original suggestion, but passed its own proposal (for a city-wide study of needs). While Federation gave no indication of approval of the NCH proposal for city-wide study (indeed, it was against this idea), NCH proceeded on the assumption that it would be implemented. An exchange of letters between the agency and the planning staff indicated the severity of the misunderstanding. Reflecting on the meeting, the Executive of Federation responded, "I hope there is no assumption on your part that I was in agreement with the only plan which seemed possible to your Board at the time." The Agency seemed to have retreated to its original stance that it was opposed to any structure which would result in loss of its autonomy.

5. Strategy Choices

Again Federation was faced with a number of possible policy choices:

- (a) Yield on principle of merger, thus maintaining the status quo,
- (b) Temporarily postpone merger discussions,
- (c) Plan with ABC as if it were community wide agency,
- (d) Use power plan to force action by NCH.

After consideration of the alternatives, the following plan was adopted:

- (a) The "issue does not warrant a crisis of confrontation . . . since time would justify Federation's position."
- (b) Federation should no longer try to sell merger.
- (c) The merger committee should disband.
- (d) Federation should continue to respond to further requests by the agencies for planning assistance through the normal administrative channels.
- (e) A report summarizing the merger discussions to date and the concerns of the agencies which prevented merger would be made public.

Thus, after nearly two years of discussion, merger seemed dead!

6. NCA Committee: Rescuing the Principle

Meanwhile, the NCH committee, which had originally been the NCH representatives

to the joint committee to study day-care on city-wide basis, met instead to examine NCH's position in regard to possible consolidation.

Free from the necessity of having to respond to a Federation proposal, this committee thought through the principles on which it would insist in any further planning. As its Executive's retirement grew closer, the Board seemed more willing to accept the inevitability of merger. The principles this Committee recommended included:

- (a) A Board for a merged agency should be a joint Board from both boards as they presently exist.
- (b) The joint board would be vested with final authority concerning budget, policy, etc.
- (c) The Executive of the consolidated center would be designated by Federation and approved by the Board.
- (d) Upon recommendation from Federation, the First President for a one year term would be from the Board of NCH.
- (e) Half of the vice presidents should be evenly nominated from the existing Boards.
- (f) Key committees should have a chairman or co-chairman from NCH.
- (g) A subcommittee on regional planning should be developed.
- (h) Mrs. K., the NCH Executive, would be retained as a Consultant to the Head Teacher of NCH.

When these ideas were presented to Federation for discussion, it marked the turning point in the merger discussions. Federation felt that these recommendations marked "real progress", in the merger discussions. The Federation Planner felt the concerns presented by NCH were valid. In response to specific recommendations, however, there were several points of contention.

(a) Federation felt that it was clearly a Board (new Board) function to hire a Director and this could not be a mandate from Federation. However, there was an assumption that Mr. N., present Director of ABC, would become the Director of a merged agency. If NCH had any reasons to doubt Mr. N.'s ability, they should be made clear.

(b) Federation felt that determining in advance that half the key positions would go to each Board might perpetuate the existence of two agencies rather than a united Board. Again, the new Board should make these decisions.

(c) Regarding a sub committee on planning, this would be a natural function of the new Board in concert with the appropriate Federation planning committee.

Federation praised the agency for its "statesmanlike attitude" toward merger. The importance of this meeting was the basic agreement that merger is needed, and that there was a willingness to work through the details.

7. Finalization

From the point of view of Federation, the major planning task was accomplished when, as a result of the principles outlined by the NCH Committee, both agency Boards officially affirmed the principles of merger and agreed to work jointly toward its implementation.

At the request of the two agencies, Federation's merger committee was reactivated, and the planning director was asked to assume the role of negotiator. A series of important planning tasks was developed. These issues included:

- 1) the future of NCH
- 2) Status of Mrs. K.
- 3) Board committee
- 4) Selection of first officers
- 5) By-laws
- 6) Timetable

A small committee, two people from each agency, was appointed to propose solutions to these issues, and to report back to the full committee.

Once the principle of merger was approved by each Board, none of these issues proved too difficult to work out.

As a result of the continued negotiations, the following decisions were agreed upon:

1. A new agency would be created with two branches.
2. Mr. N. would be the new Director.

3. NCH would maintain identity as a separate branch with its own director.
4. Mrs. K. would be employed as a consultant.
5. All present Board members of each Board would be invited to serve on the new Board.
6. A slate of first officers was agreed upon.
7. By-laws were revised by developing comparative analysis of the current by-laws of each agency and compromising when there was disagreement.
8. The final implementation took another full year, during which time the agencies operated normally, although some joint programming was attempted.

Merger was formally finalized approximately four years after the initial discussions.

Summary

How was the Planning Director able to successfully manage this four-year merger process? Of primary importance was the clear articulation of the desired goal, and the principles behind that goal. Throughout the process, these goals and principles remained intact. There was a willingness to accept the fact that either agency might not be able to accept the goals at a given point in time. Therefore, there was a continuous education program and an attempt to expose the agencies to other viewpoints.

The process was continually an open one. Minutes and memorandum were constantly shared. The Planning Director selected when to meet separately with the agencies, or in joint committee.

The Boards of the three parties played key roles and were always involved

Finally, the Planning Director used his skill as a negotiator during the difficult policy decisions.

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Herman Levin

In this case, there are obvious benefits to be reaped from merger of parts of the Jewish sectarian social welfare system. Nevertheless, much of the urgency for merger seems to derive from the United Way's pressure to achieve a unified approach to planning for day care, which, in itself, does not necessarily promise improvement for the entire community. It is interesting that a sense of urgency should be so pervasive and persistent, in view of the four years it will take to achieve it and the decision of the Federation to avoid a show of power.

A number of factors combine to create the very crisis that the Federation's Planning Director hopes to avoid:

1. The need for more dollars to support voluntary agencies. An urgent funding and planning problem faces United Way because of the difficulty in collecting sufficient money through voluntary contributions. This is aggravated by accusations that funds have not been allocated for new services or for facing such issues as poverty, racism, etc. United Way has, therefore, begun to shift from the funding of agencies to the funding of selected programs, causing agencies to re-examine their services.

2. The historical relationship between central planning and funding councils and direct service agencies. There is continuing debate about the meaning of agency autonomy in the face of the central funding agency's control over finances. The Planning Director contributes to the power struggle, and it is only after he removes himself from the fight that concrete merger planning occurs. The unanswered question remains--How are community planning responsibilities assigned and shared among social welfare organizations?

3. The vested interests of social agency boards. The boards of each agency, especially NCH (noted for its use of skilled professional staff), have vested

interests and concern about their own continuity. The Federation's Planning Director seems to have had little regard for the "details" which ultimately mean life or death for merger. Quite accurately, the NCH Committee has rescued the merger principle.

4. The continuing relevancy of a sectarian area of the voluntary social welfare sector. Several lively issues emerge here. Since NCH offers services on a "non sectarian" basis, its continued existence could be evaluated in relation, not only to other Jewish agencies, but to non-sectarian programs. Relevant questions are, "What is the basis for defining a service as sectarian?" "What is the Jewish content of the agency's service?" Literature suggests that the answer is not necessarily in the religion of the agency's clientele. The issue is creating heated arguments between sectarian and non-sectarian welfare forces.

Questions for Teaching

1. What is the place of "authority" in the professional planner's repertoire of skills?
2. In the intricate relationship between service agencies and central planning and funding organizations, which concerns about autonomy have current validity?
3. To what extent can a community forego efficiency in delivery of social service so as to preserve social, cultural and psychological values long associated with agency development and maintenance?

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COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

Bureaucratic "turf" protection is a known device in most institutional settings. Once established, the agency, function, or service assumes a life of its own, nurtured and fostered by the administrator, client and/or executive (including board) concerns.

Often, the client's concern is of less importance than the consideration of tenure and status of the administrative personnel and the sense of importance of the members of the board. The control and power of the board members, which collectively as an agency may not be of great moment, or the individual board member, because of friendships, interlocking relationships, past service and financial resources and contributions makes changes in institutional structure a mine-field of managerial decisions.

The interlarding of the two boards in the merged groups under discussion has been followed in private and public mergers. In the short term, such mergers operate to the detriment of the total organization because the merger has been an interlarding rather than an integration. This is particularly evident in business mergers where there might be a dominant personality on one or both boards or in an executive position. Thus, the merged group operates as a parfait instead of a true mixture with the fears and constraints mirrored in the operating levels as well as in the executive suite. The integration occurs only after the "old" generation leaves and a new one takes over and even then the vestiges of the two merged organizations remain.

It is more than likely that it is the personnel and human relations problems which seem to demand that this type of interlarding occur in order to accomplish the merged results. The problems of the merger are intensified and prolonged by these human behavioral problems and considerations. One solution would be to go

outside the two organizations for a new director to reconstitute the board, since the organization has assumed new and expanded functions and requires, perhaps, a new board approach in its policy and direction.

The function of the planning agency in this situation seems to be that of the midwife - unable to initiate and direct and only to take action if the situation demands it. The planning department operating in the staff capacity without implementing authority remained on the sidelines and the merger process dragged on for four years. These four years involve institutional bickering, financing and reduction of effectiveness of the client and program direction.

Whether and how the planning department can institute change are vital. Strategic planning is not the process of making plans for plans sake, but to perform and achieve today what is anticipated and desired in tomorrow's environment.

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IMPLEMENTING TITLE XX IN A COUNTY BOARD OF ASSISTANCE

by Felicia Foulkes, A.C.S.W.

The setting is a small social service department (35 workers) in a medium-sized county board of assistance (175 total staff). Social services have been separated from financial assistance in this CBA since 1968. The director of social services has been with the agency since 1970, and in her present position since 1972. The situation described here relates to the beginning of bringing the social service department into compliance with the requirements of Title XX of the Social Security Act, which took effect on October 1, 1975.

Several organizational changes have taken place in this department since 1970. "Short-term" and "long-term" service units existed between 1970 and 1971, at a time when staff members were questioning what kind of service CBA's should be providing and, thus, what their jobs should be. Following this, from 1971 to early 1973, service workers were assigned duties of eligibility determination for financial assistance, due to shortage of staff and backlogs in this area. In June of 1973, with all service workers back in the service department, a new organization was implemented which has been maintained with very little change since. Under this system there are four functional units (in addition to clerical and planning units); one providing crisis intervention and short-term counseling in a number of areas (e.g. housing, health, child care, legal problems) and three supplying the social work component of multi-faceted programs (two health and one employment).

Title XX of the Social Security Act provides guidelines for states social service programs including requirements for federal financial participation, replacing Titles IV-A and VI. Under these regulations Pennsylvania decided to offer 20 kinds of social services to eligible families. These services are to be provided either directly by the county boards of assistance or through contract

with day care centers, child welfare agencies, mental health/mental retardation centers and other similar agencies. Most of the 20 services are either being provided at the present time by the CBA described here or are clearly the responsibility of other agencies via contract. In several areas, however, changes in the CBA service system are needed. Service planning/case management, one of the 20 services, does not now exist in this social service department, although one or two of the functions subsumed under this service are being done in other ways. Employment services (to clients not enrolled in the WIN program) are also not presently being provided. And finally, in several of the 20 service areas (Housing, Counseling, Life Skills Education and Socialization/Recreation) we have been, in most cases, referring the client to other agencies. Now, within the limits of available staff time, there is a chance to provide more extended, varied types of help ourselves.

The questions to be answered at this point are essentially the same ones which the social service director has been facing during the last two years:

1. How to provide direction, structure and accountability in a bureaucratic organization and at the same time allow for sufficient staff involvement so that creativity and a sense of responsibility for and satisfaction in one's own work will be maximized.
2. How to mesh federal-state requirements¹ with local conditions and local experience so that the services provided will be appropriate to the needs of county residents and will be delivered in a way which takes into account the characteristics of the area and the population.

Translated to the fall of 1975 and Title XX, this means how and to what degree should the staff responsible for service delivery be involved in the changes that are needed, and what changes should be made in light of local conditions and agency experience, without having "all the facts in" as to how the state would implement

this new federal law.

Decisions for the social service department are made at one or more of four levels: 1) by the social service director in consultation with the agency's executive director, other agency administration or regional or central office DPW staff 2) at social service supervisor's meetings, held approximately once a month, in which the social service director participates 3) by the social service director and an individual service supervisor, regarding a particular program, at weekly conferences 4) by unit supervisor and unit members, at unit meetings and in individual conferences. The decision, then, was which of these "models" to choose in this situation.

The first step taken was to call a meeting of all social service staff, at which the social service director discussed, in general terms, what Title XX was likely to mean for the social service department. (There had been considerable concern that a major "shake up" would be coming and that all jobs would be different, which, in fact, was not to be the case). The next decision made was that a framework needed to be developed in which new requirements could begin to be related to current organization and job duties. It was decided that this initial work should be done by a team of three: the social service director and the two supervisors who are most closely involved with the program areas in which changes will occur. Four three to four hour meetings were held, chaired (and later recorded) by the social service director, with agenda items contributed by all three members. The results of these meetings were:

- 1) a two-page outline of "service management unit" procedures, indicating new forms which will need to be filled out and the routing for different kinds of service requests which they will receive.

- 2) a listing of the Title XX service areas, the particular service requests under each which we will probably receive, and one-three possible ways each request can be handled by this unit.
- 3) a form which will be used to record Information and Referral contacts by the service management unit, which will allow for follow-up on service requests. This is not a federal or state requirement at this time, but is felt to be needed in order to insure proper service to clients who contact us.
- 4) the decision to implement the new system at the beginning of January, 1976, (about five weeks from the date of the last team meeting) whether or not final forms or further details for implementation have been received. (The reason for this is the opinion that one of the basic federal requirements not likely to be altered is that requiring centralized service intake, which we do not have. Also, Title XX defines services differently from the way we have been doing it. The new service definitions are needed for new federal reporting requirements which do not seem likely to be changed in the near future).
- 5) Next steps in decision-making and implementation will be made in the "traditional" fashion, i.e. supervisor and workers who will be providing the services, and supervisor and social service director.

The latter decision has been implemented by setting up two working groups, one of which will be providing service planning/case management services, the other the expanded services in the areas of Housing, Counseling, Life Skills Education and Socialization/Recreation. The service planning group has taken the framework (1), 2), and 3) above), filled in the gaps (more detailed decisions) and defined and

then divided up the tasks that need to be completed before the unit can begin operating. The group that will expand its services has met and been asked by its supervisor to answer several questions, to help move ahead to a clear definition of the new jobs. The questions are: 1) What have you done in the past with this type of referral? (i.e. Housing, Counseling, Life Skills Education, Socialization/Recreation). 2) How would you like to expand this activity? 3) When, if ever, would you refer problems to another agency? 4) What expertise do you now have that would enable you to offer this expanded service? 5) What additional training do you need (in order to offer the expanded services)? Reports of these working sessions are taken back to the supervisor, who then works with the group on next steps.

At the time this work is progressing an offer of training has been made to the social service director by the social work department of a local college. It is possible that a course can be designed to deal with areas where we feel training is needed. A meeting has been arranged for early January which the instructor and social service staff members will attend. Staff members will discuss their jobs, particularly the new elements, and tell the instructor what training they feel they need to do these new jobs well. On the basis of this meeting, and of the plans and time of a social work graduate student placed with the department this year, definite plans for training in Title XX service delivery will be made.

1 An added point is that often the federal regulations come out and must be implemented before state policy and procedures have been fully developed, leaving important questions unanswered when programs begin.

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Richard Estes

A. This executive feels keenly that staff members at all agency levels should participate in the selection of program priorities which best reflect the service needs of the agency's clients.

What are the special administrative problems inherent in this approach to management given:

- a. The staff's knowledge of the special service needs of the target population?
- b. The staff's level of knowledge of legitimate client needs which fall outside of the agency's function?
- c. Requirement for a coordinated county-wide planning effort?
- d. The reality that most of the state's social service planning occurs at the state level far removed from the local office and, then, generally in response to (1) prevailing federal priorities and pressures; (2) state fiscal constraints; and (3) state-wide needs?

What alternative approaches might this executive take to free staff to implement Title XX programs to best reflect local client needs?

How might this executive and his staff effect planning at the county, regional, state and federal regional levels? Is this an appropriate activity for the local agency?

B. How might this agency's decision-making mechanisms be further refined to allow for a broader range of staff participation? What opportunities are inherent in each of these changes and what are their potential problems, given the director's need to make decisions within a timely manner?

C. What potential managerial problems might the executive be creating in his effort to reassure staff that mandated organizational changes will not result

in a major "shakeup?" How do you view this reassurance, given the expansion of functional areas of responsibility, the requirement for more continuity of services and the pressures for more comprehensive case planning?

D. In what ways do these worker and agency role shifts require further planning and training? What role might the local college carry? What administrative problems are inherent in effecting such major changes in a short time period?

What type of professional should provide the needed staff training? Is a graduate student sufficiently prepared to carry this level of responsibility? What support might the trainer(s) receive as he/she moves through the training process?

E. Where has responsibility for monitoring the agency's service effectiveness been lodged? What are the executive's responsibilities in this area? Those of the social service director? Those of the line and middle management staff?

How must the public and consumers be involved in the planning, provision, monitoring and evaluation of Title XX social services? What are the probable impacts of this involvement on the agency, its staff, planning process and shifting service priorities?

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COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

The planning process encompasses an identification of the central issue or problem, the determination of alternatives for possible solution, the choice of a decision, and the implementation of the designated choice.

In this situation, the agency director incorporated the steps in a coherent and rational fashion. In addition, the director invited and received the inputs of the supervisors and employees as to their suggestions after the group identified the basic issues or problems and then set about to establish alternatives.

In doing so, the entire organization became part of the planning process and in doing so established goals and objectives which might be more rationally achieved.

With this type of input, participation and involvement, the implementation becomes the much easier. Employees do not feel threatened by new approaches, new services or new duties and responsibilities. There is understanding of the procedures in written form and on implementation. Implementation is the more vital and volatile area in administration. What is proposed might not adequately meet the needs of the clients, organizations, or its staff. Changes must be made to insure that the objectives of the plan are observed and achieved. The implementing process calls for flexibility in approach and constant evaluation as to whether the goals and objectives are met. If not, one must change the procedures accordingly and determine whether the goals and objectives are correctly stated or over or understated.

In other words, the planning and implementation process is a crucible in which the basic ingredients are tested and tried.

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THE EXECUTIVE RESPONDS TO FISCAL ACCOUNTABILITY

by Andrew Masiuk, M.B.A., M.S.W.

Introduction

A new executive director of the Philadelphia County Board of Assistance (PCBA), appointed in February, 1972, faced two items of high priority: to reduce the number of ineligible welfare recipients and to minimize overpayment in welfare grants. The Executive Director took strong measures to bring ineligibility and overpayment problems under control. Indeed, 1972-1975 statistics show an impressive drop in both of these categories. The Executive Director feels, however, that the initial measures have fulfilled their goals. He is contemplating, therefore, a plan that would provide PCBA with a permanent handle on the two problems. He is currently piecing together such a plan.

The Agency

The Philadelphia County Board of Assistance administers income maintenance and social service programs (including food stamps) for more than 115,000 needy residents. It operates out of 18 district offices and the central administrative office. PCBA employs over 3000 persons. A breakdown by position is given in Appendix II.

The two main functions of income maintenance and social services are provided separately by different staff. The income maintenance function (or cash assistance) is by far the dominant one within the agency. It is within the context of income maintenance that the problems of ineligibility and overpayment arise.

All the employees of the agency are part of the State Civil Service complex. Two unions represent most of the employees below the administrative level. AFSME (AF of L) represents the clerical staff while Pennsylvania Social Service Union (PSSU) represents the caseload workers and the front line supervisors. Contract negotiations during 1975 were quite difficult and agreement was not reached without a strike.

The negotiations were with the Commonwealth of Pennsylvania.

The Style of the Executive

The Executive Director administers the agency through a well-defined chain of command (see Appendix III). The operating policy for the agency is established by the Executive Director and by the five administrators who report directly to him. Four of these administrators are titled Directors of Operations and the fifth has the title of the Director of Management Services. These six persons meet once a month to establish and to review the agency's operating policy.

The Executive Director relies heavily on his lieutenants not only in the formulation of operating policy, but also in its implementation. His lieutenants have in this sense both line and staff responsibility. Each Director of Operations supervises the operations of four to six district offices. Such a director is the link between the policy generating committee and the supervisor of a district office. The District Office Supervisor receives agency policy decisions from the director of Operations and is responsible to him for the performance of the district's activities in accordance with policy.

The Executive Director believes that the proper use of the chain of command is essential to the well-functioning of the agency. It provides him with the necessary control while keeping to a minimum the ambivalence toward policy among staff. Directives and decisions on specific issues travel through the chain from the Executive Director to a designated spot in the chain; the route is pretty much the same for a problem, demanding his attention, to get to the Executive Director. The Executive Director has respect for the authority vested in each level in the chain and conducts his activities in a way to support the legitimate authority of his subordinates.

THE PROBLEMS

The problems of ineligibility and overpayment are essentially problems of

accountability. Information about the existence and the extent of these problems comes from auditors that are external to the agency. These auditors represent the funding authorities within the State and Federal governments. A persistently high occurrence of ineligibility and overpayment carries with it the threat that some funds will be withheld from the agency by the funding authority.

Since the two problems occur at an interface of the agency and other entities--notably the funding authorities and the client groups--the Executive Director, as the representative of the agency, is directly involved with their effects and with their solutions. The funding authorities want overpayment and ineligibility at an absolute minimum and they pass this message to the Executive Director. The client groups want an effective service with a minimum of red tape and procedural obstacles. They, too, make their wishes known to the Executive Director. The Executive Director, through the vehicle of operational policy, legitimizes these demands and passes them on to staff.

Within the agency, the problems of ineligibility and overpayment are comprehended in terms of caseload coverage. A caseload is in coverage if each case record within the caseload has in it the prescribed information, up to date, and the correct payment amounts authorized on the basis of that information. Cases that do not have current information or do not show properly adjusted grants detract from caseload coverage. Thus, for example, if in a caseload of 100 cases there are ten cases that are deficient according to the above criteria, the caseload is 10 per cent out of coverage. The relationship between coverage and ineligibility and overpayment is that the latter two occur only in cases out of coverage, although not every case out of coverage is characterized by overpayment. The Executive Director developed a plan to move in the direction of getting the caseloads in coverage.

The Approach

In the Fall of 1972, 20 per cent of the cases in the agency were out of coverage. With the collaboration of his 5 assistants, the Executive Director developed a plan of

action to reduce the above percentage and at the same time reduce ineligibility and overpayment. The plan of action was three pronged: extensive training for employees; reduction in size of caseload; dialogue with the representatives of the client group--WRO.

Training

Training was provided in two areas: (a) manual material and (b) casework and interviewing skills. Training on manual material was provided "in-house", i.e., by employees of the agency. It stressed the policy and procedural issues, the understanding of which was essential for keeping cases in coverage. The training in casework and interviewing skills was provided by a state college on a contractual basis.

Caseload Size

In 1973 caseload size varied from 140-180 cases. This was considered too high for proper caseload management. By hiring more caseload workers, the average caseload was reduced to 115 cases in 1975.

Work With WRO

The Executive Director arranged regular meetings with WRO representatives. The result of these meetings is that workers who deal directly with clients--interviewers and caseload workers--were given training with special emphasis on sensitive interpersonal behavior. Sensitive workers, it was hoped, would not only provide better service to the client, but would be in better position to manage the client's case.

1976

Ineligibility in the fiscal year 73-74 was at 11.2%. It dropped in the succeeding year (74-75) to 9.4%. Although caseload coverage fluctuates considerably from month to month, there was substantial improvement from 1972 until the present. The Executive Director is looking for a way to depress the ineligibility percentage to 3%--

a level deemed acceptable by Federal Government standards.

The initial efforts (the three-pronged approach) has set a favorable trend; what is needed now, the Executive Director believes, are organizational adjustments that would capitalize on this trend and in fact reduce ineligibility to the 3% level. The organizational adjustment that the Executive Director is contemplating is in the area of job design.

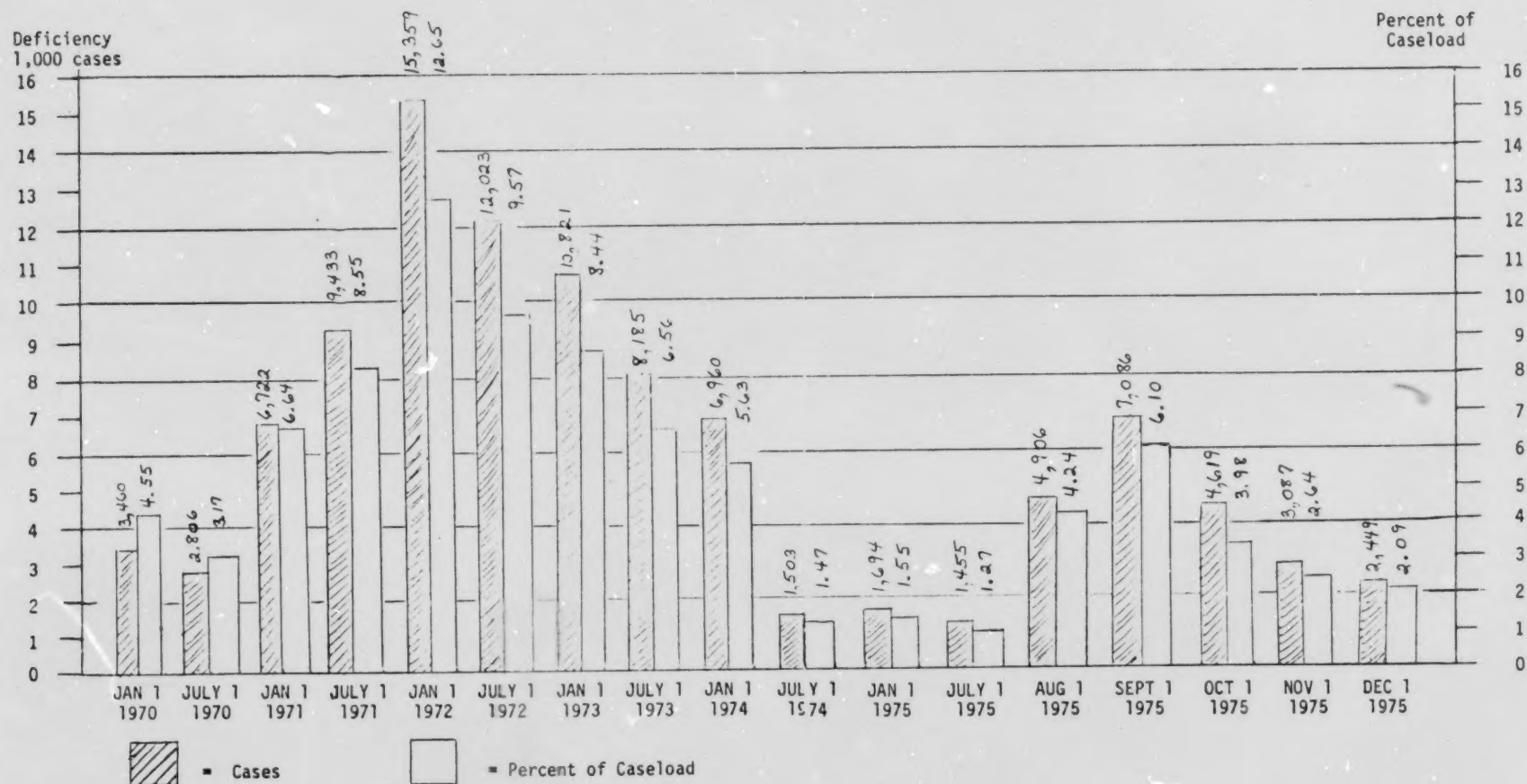
The job design that the Executive Director has in mind, he calls "the team caseload concept". Under the team caseload concept, the responsibility for caseload coverage would rest primarily with the supervisor rather than with the caseload worker. The unit supervisor will in effect manage a unit caseload (a unit consists of approximately six individual caseloads). In managing the unit caseload, the supervisor will be free to use the caseload workers on the basis of what needs to be done in the unit as a whole. Currently, each case worker is responsible for his individual caseload and, although he may be asked to help out on another caseload, he considers his caseload the domain of his activity. The difficulties under the current system arise when a worker is absent from a caseload for a long period of time. This may be due to illness, Jury duty or other reasons for temporary absence. This will also occur when a worker quits the agency. It is not uncommon to experience substantial delay in filling a vacancy.

The team caseload concept would afford the supervisor much more flexibility in assigning workers to tasks which are demanded by the unit caseload. A worker will be responsible for the effectiveness of his work on a particular case, but the planning necessary to maintain cases in coverage will be done by the supervisor and it will be done on the basis of all the cases in a unit.

The Executive Director feels that the "team caseload concept" will equalize the workload on caseload workers. Additionally, aided by necessary seating and spacial arrangements, workers will be in a position to share expertise with each

other, and in general help each other in getting "the job done". The seating arrangements will be such that two workers sitting next to each other will serve neighboring geographic areas in the community. (The Executive Director calls it contiguous districting). The supervisors, on the other hand, will be in a position to manage and most importantly plan to meet coverage requirements for the whole unit.

PHILADELPHIA COUNTY BOARD OF ASSISTANCE
NET DEFICIENCY - ABSOLUTE AND AS PERCENT OF CASELOAD
SELECTED POINTS IN TIME - January 1, 1970 to December 1, 1975



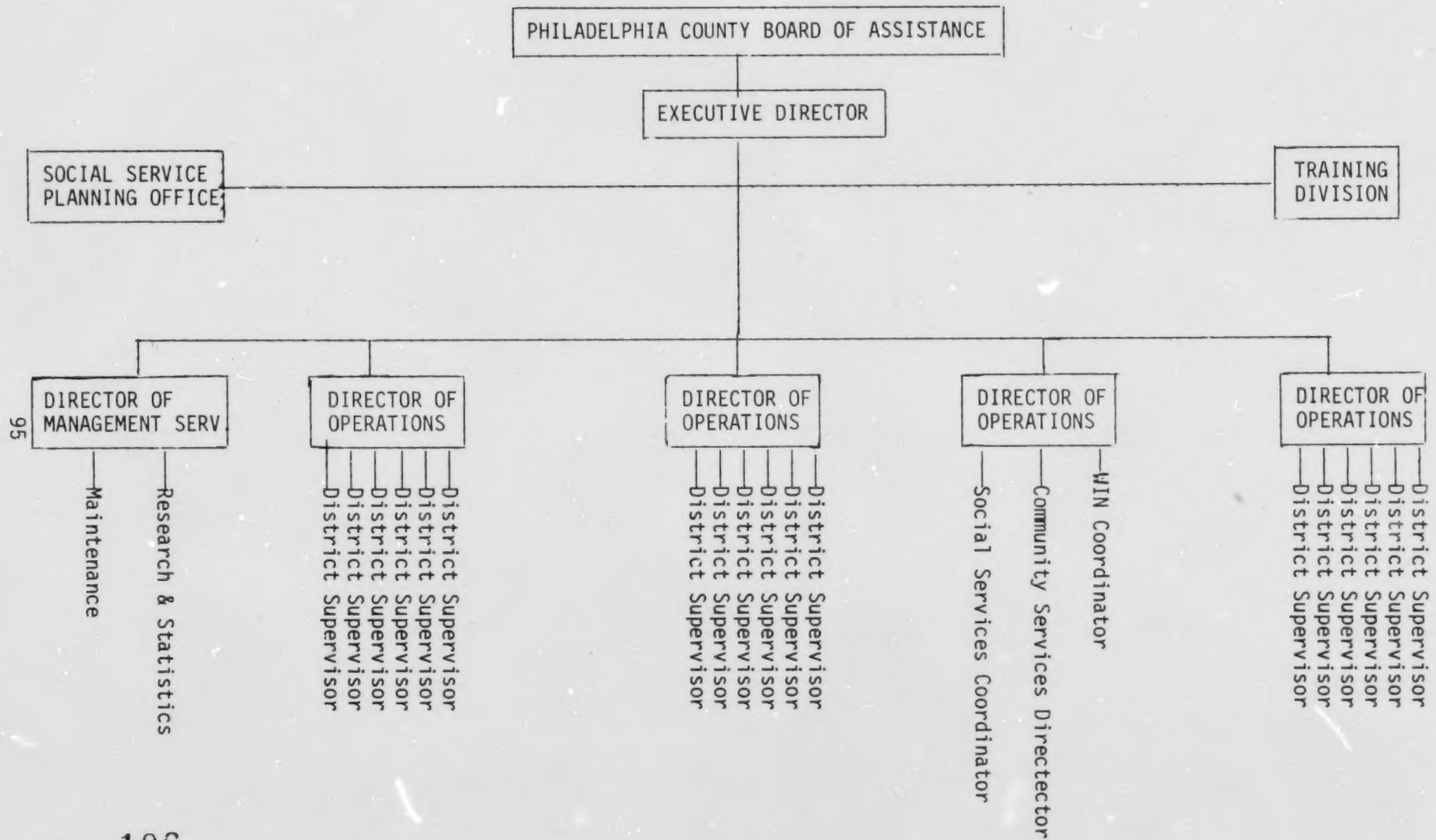
APPENDIX I

APPENDIX II

PHILADELPHIA CO. BOARD OF ASSISTANCE STAFF AT THE END OF 1975

Application interviews	233
Food stamp interviews	1
Verification workers	9
Caseload workers	1180
Workers in training	48
Supervisory staff	293
Administrative staff	76
Clerical	1107
Human Service Aides	40
Homemakers	22
Other	25

APPENDIX III



COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Herman Levin

The administrator views the solution to his problems--reduction of the number of ineligible welfare recipients, and minimizing of overpayments in welfare grants--in the development of an effective "span of control" over the work practices of caseload workers.

Issues to be considered are the number of cases covered by a worker and the number of caseloads and caseload workers (i.e., the Team Caseload Unit) to be controlled by an individual supervisor. Of necessity, the decision regarding caseload and Team Caseload Unit size requires concurrent decisions relating to information feedback, personnel needs and in-service training. While the case material suggests satisfaction with the amount of success in reducing ineligible cases, it does not demonstrate achievement of success or give reason for assurance that the improvement can be sustained. Many factors account for uncertainty:

1. The political climate in which the agency operates. Funding accountability is different for each constituency. State and federal government want to lower the size of the public assistance rolls and of expenditures. Clients want the assurance of full benefits to all eligible beneficiaries. The administrator must weigh political necessities. It is significant that there is no mention of "underpayments" to beneficiaries or of persons incorrectly found ineligible. Management's primary objective, then, is cost reduction, and the situation remains politically volatile.

2. Disjunctures between responsibilities for policy and program development and for program implementation. The administrator has little participation in the former and full responsibility for the latter. Even here, however, he may not have the necessary control to achieve re-organization. The County Board is subject to state regulation, and political pressure felt at the state level could be reflected in operational practices of the County Board. The absence of local responsibility for policy and program development holds some danger that County Board personnel may

carry little stake in achieving the program or administrative objectives.

3. The possibility for administrative and professional conflicts. The institution of in-service training in casework and interviewing skills suggests a low level of professional preparation, where a high degree of ability seems necessary. If so, establishment of Team Caseload Units raises these questions: How can the supervisor handle approximately 690 cases? What will be the effect of the less clearly defined boundaries and content of the caseload worker's job? Lack of clearly defined administrative responsibilities may aggravate professional dissatisfaction. The administrator's decision in favor of a tighter formal structure and the potential for severe professional-bureaucratic conflicts cannot be discounted.

Question for Discussion

1. The extent to which political constraints define effectiveness and efficiency in the administration of a public welfare agency.
2. Handling of professional-administrative conflicts.
3. The influence of social and professional values on the development and implementation of administrative procedures.

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COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

Fiscal accountability requires quantitative results so that an evaluation can be made. Here the results are quantifiable. Caseloads and improper payments can be determined and the standard established as to what is a proper caseload and an acceptable percentage of "out-of-coverage."

The value of the quantitative approach is, as in MBO, the establishment of certain goals, the determination of an acceptable approach from among a number of alternatives, and a plan for achieving the objective. While the plan is put into effect, the manager/administrator can see on a weekly, monthly, or quarterly basis how well that goal is being achieved. At any point in time, the manager/administrator can modify, correct, or maintain the plan to achieve those ends or re-establish a new set of goals if they are not rational or if they are unobtainable with the resources available.

This type of planning and implementation requires a table of organization in which each level is held responsible for the results. In this case, the Executive Director gave responsibility to his lieutenants, both with respect to formulating policy and its implementation. Goal-setting is precise and unmistakable. The technique for its achievement is established in formal procedures and direct contact with the staff, and then with others and other levels of control.

The Executive Director established a team approach to the caseload -- for the sharing of the load and to protect individual members of the team whose statistical records might show either too great a liberalization or too much stringency.

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MONITORING TOOLS - CASE A
GRAPHING - AN INTEGRATIVE SERVICE PROGRAM MONITORING TOOL
by Alex Jones, M.S.W.

Maryland has a state supervised, locally administered public social services program. The supervision of local social service programs is the responsibility of the State Department of Social Services and is executed primarily through the five regional field units of the Bureau of Field Operations. While each field unit has the same overall responsibilities, there has been freedom to experiment and develop methods that seem to work best within the respective regions.

This paper will describe the need, developmental process, benefits, and limitations of one monitoring tool now in use in Region I.

THE NEED

How does one monitor (without computer assistance) eleven State Service programs in five unique and often contrasting counties?

The first step was to decide what needed close monitoring. Our conclusions:

- 1) how many people were asking for which services
- 2) the local department's responses to them (in aggregate)
- 3) how many needs were met (via closed cases)
- 4) problems which may prevent delivery of service

Such data would be cyclical in nature, originating with the local departments and reviewed with them to guide decisions for improvement of the delivery of services.

The second step was to review existing methods of monitoring.

- 1) Case readings could provide certain kinds of data. However, these readings could not provide the number of case actions in a program and would be extremely time consuming if used on a large scale basis.
- 2) A monthly statistical report (250) which contains as many as 68 data items related to the adoption program alone. However, this reflected only one month's operations and did not seem to be as comprehensive as we wanted

or lacked the statistical machinery to supply the data necessary to support most of the effectiveness/efficiency measures. Often it was distributed three to five months after the month described. Its statistics were statewide and had little program detail.

We wanted one tool that would give the "vital signs" of each program in each county department at a glance. Ideally, such a tool would be able to record what has already happened, what is now happening, and would have a certain predictive quality to it as well. For maximum value, this tool would tie in as many of the local department internal operations to as many of our state operations as possible. Early dreams visualized a "program trail" beginning with the worker, moving to his or her supervisor, to the local statistical unit, to the administrative officer, to the State Department of Social Services, our statistical and fiscal divisions, field operations and back to the local department.

Such a tool must not add burden to an already overloaded local staff and it must be objective, based on details of local program operations. It must have credibility, local and state support, some degree of permanence, and be non-threatening.

We found that such a tool did not exist, but that the raw materials for its development did exist.

DEVELOPMENT PROCESS

We speculated that agreement on and graphing of common denominators in all of the programs could result in a tool which would accomplish our objectives.

A review of the tools used by the State Program Specialists who develop and clarify program policies revealed that they were designed to meet other objectives. None had experimented with graphing. However, many did identify areas in their programs which they considered to be basic.

A review with local departments identified six inter-related areas that would

be most helpful in future periodic reviews. The specific statistical data could be culled from our 250 monthly report.

1) Applications. We speculated that graphing this item would provide a fiscal year record for each local program which could be compared for other periods of the year and for the next fiscal year. The same programs in similar sized counties could then be compared. Dramatic increases and decreases would signal the need for review. As our "intake door" this data item would also tie community needs to our service delivery capability. It could also be helpful in the allocation of staff and in the transfer of staff within any department. Thus, high unemployment could be reflected by a higher than usual number of applications in our SFDC Program.

2) Cases Pendings. We speculated that graphing "pendings" would show how many cases were backlogged at intake, which should reflect "applications". If any program consistently ran a high "pending" count, we could look at the detailed reasons to resolve the problems. "Pendings" could also reflect the capacity of other community resources. For instance, pending home studies may be held up waiting for the Health Department testing report of well water.

3) Cases Opened. Fluctuations in "openings" should be clearly related to the number of "applications" and "pendings". A consistently low number of "openings" would signal a review for specific reasons, with remedies developed. Marked fluctuations would likewise signal a review with more of an expectation of community need changes than internal difficulties. A spurt of court ordered P.S. investigations would be one example.

4) Requests Otherwise Disposed Of, ("ODO") At Intake. Graphing this data item would show the proportion of "ODO's" to "pendings" and "openings".

A high ratio would signal review.

A fluctuating number may be both seasonal and normal, as in the case of Protective Services referrals from schools in the spring and fall.

- 5) Cases Closed. We expected a regular number of monthly closings, and fluctuations that could not be traced to fluctuations in the other "vital signs" would be reviewed.
- 6) Cases Continued in Services Into The Following Month. Logically, this figure should be a combination of cases carried from the previous month, plus cases opened, minus cases closed. When this arithmetic did not add up, we looked for local statistical division errors. This figure provided the service caseload nucleus. Fluctuations not explained by other vital signs would signal a review for causes and remedies.

RESULTS

Graphing programs began as an experiment. We have made it a tool that has been in use for two years.

We have learned much along the way. For instance, pretty colors may be nice, but they do not photocopy. Locals can't use the graphs unless they can be reproduced quickly and cheaply.

We began by having monthly reviews, only to have occasionally mistaken false alarms for the beginning of trends or fluctuations. We have found that quarterly reviews are more helpful.

We initially thought of graphs as a program monitoring tool, but we have since learned that they can become an administrative tool and a training tool as well.

The greatest learning has come about as we applied this tool to daily operations. We are still finding new meanings to the various relationships among program "vital signs".

The most confusing graph came up in our monitoring of the Protective Service Program in one of our medium sized counties. The graph shown as Diagram "A" made no sense whatsoever. (See diagrams A - D at the end of Case I.)

A review with the local department revealed a need for both training of the new statistical person and a rerouting of the monthly statistical report so that the unit

supervisors saw the statistics for their unit in the aggregate, not just by worker. This way, the statistics could be reviewed and corrected before they left the local department. The locals could be assured of having their staffing needs more adequately reflected in the monthly 250 report.

In reviewing the SFDC Service graph shown as Diagram "B" for the first five months of this current fiscal year, we noted a surprising 300% increase in cases closed for the month of September and a 100% increase in closings for October. The cases continued showed a corresponding decrease a month later. This provided some internal consistency. There were no pendings (not shown). "Applications" could be derived by adding "ODO's" and cases opened (but was not graphed as a separate line).

On site review revealed that the SFDC Unit staff had been reduced by 33% and the case closings were designed to limit the caseload to those cases reflecting definable client needs. Those with minimal needs were closed. This finding has prompted a study of the 90 clients to see what has happened to them six months after their cases were closed.

The graph shown as Diagram "C" shows a serious decline in the cases continued for services in the Adult Services Program.

Even though this decline was reviewed quarterly, the reasons changed and the decline continued. In the first eight months, closings outweighed openings. The money payments had been transferred to Social Security Administration, and we were not getting referrals for services from them. Efforts at local and state levels were made to get a referral machinery worked out. We were unsuccessful. The decline in March and April represented planned closings.

This local department was short of supervisory time during this fiscal year. When they were able to hire a new supervisor, this graph (Diagram "C") (along with graphs of his other programs) was reviewed with him. Such a review was helpful for him to get more of a programmatic perspective, look for more specific referrals and

to develop innovative ways of making our services known to those who may need them. Their graph for F.Y. 1976 is decidedly on the upward curve.

Protective Services has experienced a great deal of attention in our Region during the last several years. The graph shown as Diagram "D" will reveal some interesting and perhaps widespread trends.

For instance, the number of continued service cases dropped significantly while the number referred rose dramatically from February through May.

The number of pendings is uncomfortably high. Review of this facet revealed a lag in services from other community resources.

When we reviewed the opened case to the requests ODO'd ratio, we found that many ODO'd requests could have been opened if we had available staff time.

Additional worker time will be made soon. This decision, made by the local Director, was aided by the graphing delineation of his service program needs.

LIMITATIONS

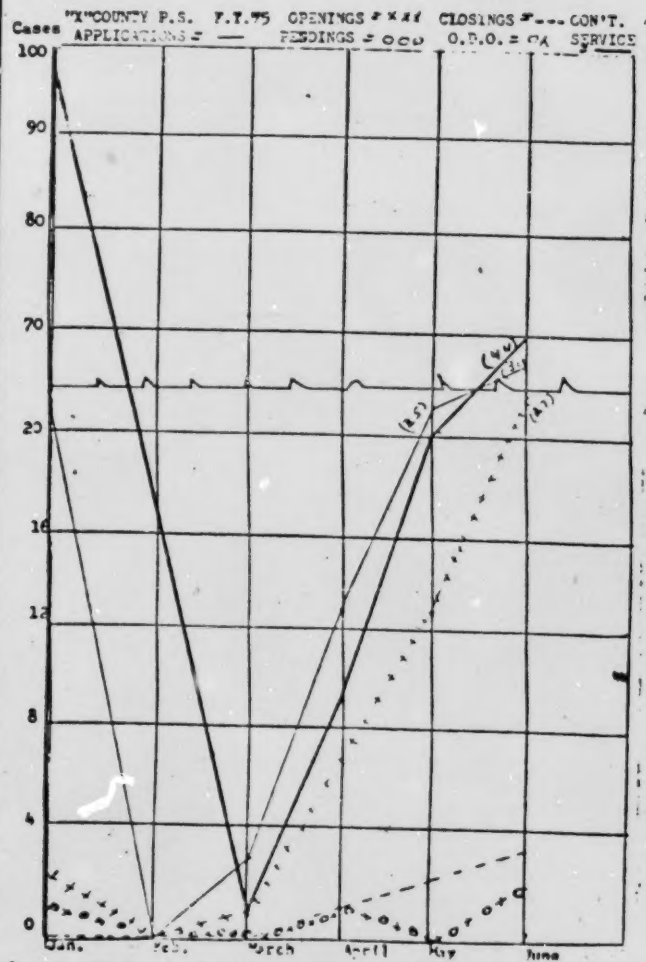
Graphing is a visual aid that has helped to delineate, record and compare quantifiable program "vital signs". It has proven helpful in identifying areas of current concern as well as suggesting possible future trouble spots. It has been used to monitor programs, reflect community needs, identify interagency communication blocks, and to train new supervisory/administrative staff. It has been used in departments which have varied in size from 200 to 3500 service cases monthly.

However, graphing will not reflect the quality or effectiveness of services in any given case. Case readings are still necessary. Graphs will not spell out why, just point to problem areas. Site visits are still necessary. We have not developed norms for "low" or "high" figures. We have to use our best judgment, integrating as much as we know about local operations before acting on a "low" or "high" reading. Costs per service case must be obtained from other documents.

Are graphs worth the trouble? We must reply with an emphatic "Yes"!

Case I - Appendix
(Diagrams A - D)

DIAGRAM "A"



Cases "X" COUNTY P.S. F.Y. 75
OPENINGS = x x x CLOSINGS = --- COM'T.
APPLICATIONS = — PENDING = o o o SERVICE
O.D.O. = ox

DIAGRAM "B"

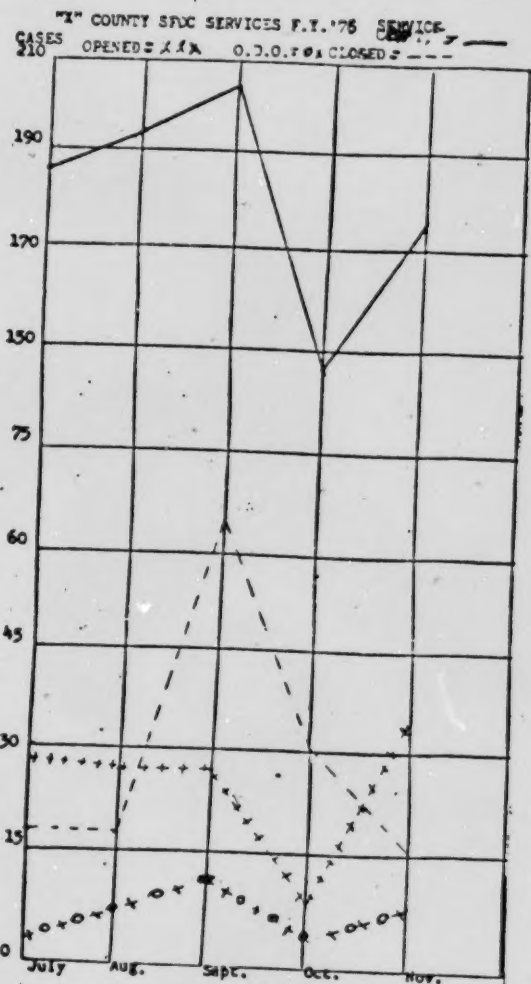


DIAGRAM "C"

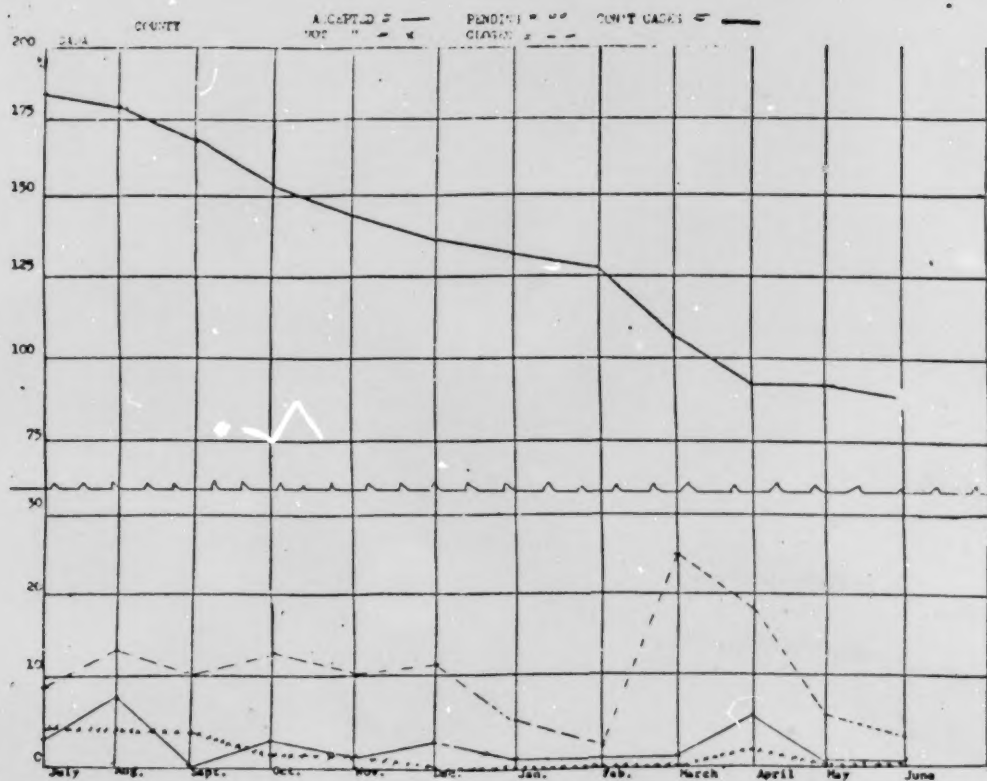
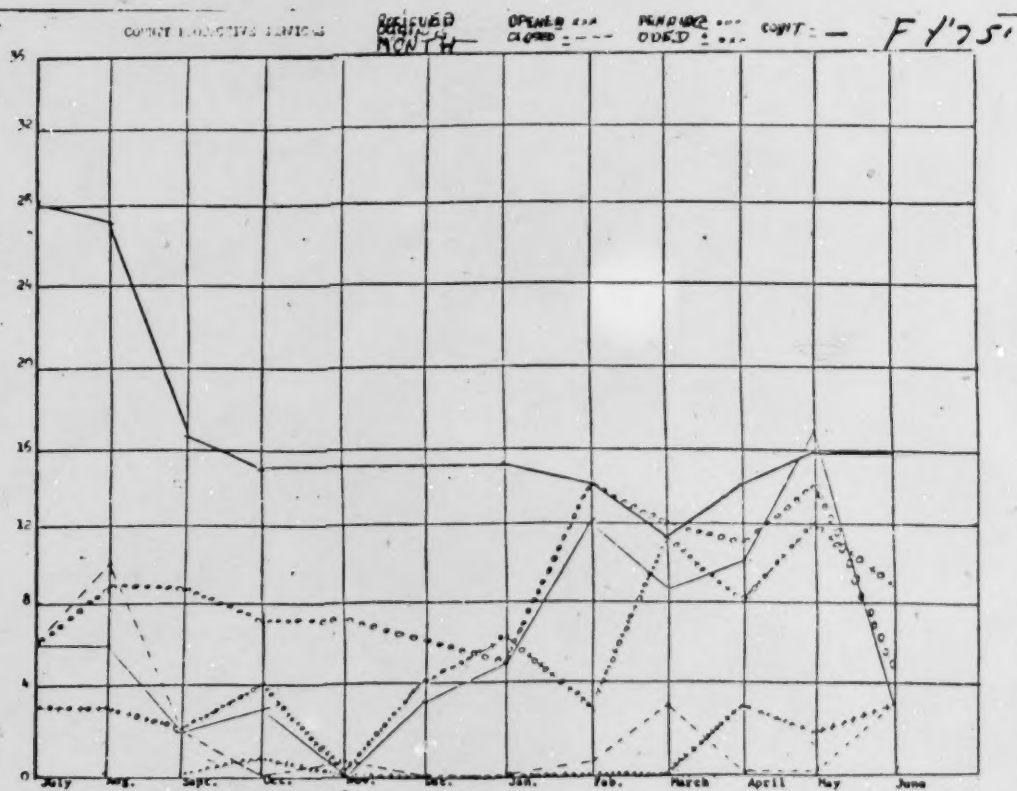


DIAGRAM "D"



COMMENTARY FROM THE SCHOOL OF SOCIAL WORK - CASE A
by Dr. Richard Estes

A. Monitoring the effectiveness of on-going public social services was mandated by the Title XX legislation (P.L. 93-647). Where does administrative oversight responsibility for this activity rest and in what way (s) does a state field office-- the base of operations described in this case-- participate in satisfying that responsibility? What form does this monitoring take and to whom are evaluative reports submitted?

B. What are the special role strains experienced by state field office staff as it carries out its joint responsibility for technical assistance to local agencies and assistance with service delivery implementation? What additional management burdens have been imposed on these relationships as a result of a more rigorous monitoring responsibility? What administrative sanctions might be used to minimize the potential negative impact of this additional evaluation responsibility at both the state and local level?

C. What might be the expected response on the part of local agency staff to having its performance effectiveness evaluated by an outside agency? How might local agencies contain the oversight responsibilities of the field office and how might these efforts succeed in defeating the essential purposes underlying the evaluation/monitoring mandate? What, in turn, might the field office staff do in its efforts to thwart inadequate reporting by local agencies? What are the serious administrative consequences for both local and state level staff if they fail to provide the legislatively mandated information?

D. What is the administrative relationship between program planning and implementation with program monitoring and evaluation? How do these various administrative activities overlap and how do they differ? What indication is there of the interdependence of these tasks?

E. Consider alternative approaches to satisfying the evaluation/monitoring mandate. Is program monitoring alone sufficient to assess a program effectively? In which areas might more rigorous research designs be developed and implemented? Where does graphing as a monitoring tool fit into the full spectrum of program monitoring/evaluation techniques? What are its advantages and limitations?

F. Consider the place of computers in assisting public social service administrators with program planning, needs assessment, monitoring, and evaluation tasks inherent in managerial positions. What are the special problems and advantages associated with adopting an automated data information system? What are the special ethical and value questions associated with the use of computers and other forms of automated data information systems to which social work managers must be especially sensitive? Identify the major issues associated with these potential ethical problems and arrive at some tentative conclusions as to how they might be resolved.

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MONITORING TOOLS - CASE B

THE IMPLEMENTATION OF AN EFFECTIVE COMPUTER SYSTEM

by Elliot Rubin, M.S.W.

This case relates the experience of Jewish Family Service of Philadelphia in developing an effective and efficient statistical information system based on computer technology, within the constraints of most Family Service Agencies: limitation on acceptability, and limitations of existing skill levels.

During the long range planning process, inevitable questions were asked of the agency staff by Board and community relating to the philosophies of service and to hard data: how many, who, how often and where. Often, staff did not have information at hand to help the long range planning committee and its various sub-committees to make decisions. Information was either not retrievable under the current system, or would have taken too long or been too expensive to obtain.

The second long range report noted that the retrieval system of JFS should be simplified and made more economical and efficient. Accordingly, a student in Social Research and Administration from a Graduate School of Social Work was placed in the agency for training in administration. His assignment was to review the agency's information and data collection system and to develop a conceptual system of collecting data that could be used either manually or with machine technology.

The guidance of many Board members involved in the long range planning committee had provided the necessary skepticism about computers so that the staff could look at the data system without becoming seduced by the gadgets of technology.

At the end of his school year, the student had completed his assignment and in his master's thesis described how the agency had restructured its entire data collection system to fit its modern existence. A brief example: For many years the agency had only one office. At the time of the student's work the agency was

decentralized and yet the data collection system was based on the system that was developed for a small staff, all in a centralized location.

While, at this point, the data collection system was still manually done, the agency had eliminated duplicate reports and had made a number of changes affecting all the forms in the agency, from application forms through record room notices, to monthly statistical reports.

A system that was coherent and internally consistent revealed staff hours used in collecting and transmitting data each month. An analysis of the agency's monthly statistics showed the true cost of collecting statistics for monthly reports.

The information was enough to raise serious questions about the amount of time allocated to internal information gathering that could have been more justifiably directed to direct service.

The agency's annual statistical report gave a mix of demographic and service statistics for the agency for the whole year. JFS serves more than 60,000 families per year. Data on interview counts, district offices, number of people in the family had to be collected on each one, taking a statistician approximately two months.

The first approach was to consider an agency owned, in-house computer and a custom designed program. Our results were the same as other FSAA agencies. Costs were prohibitive.

At this point, the agency was stalled on two major issues: (a) the machinery was too expensive and (b) the technology was alien to the conceptual framework of social agencies. Discussions to consider transforming business programs into social agency applications revealed only a few semi-adaptable programs. The cost of hiring a person to write and custom design programs for computers from scratch is prohibitively high.

The agency Executive learned that the University of Pennsylvania had recently appointed to its faculty a DSW Social Worker who had written his dissertation

on the application of computer technology to public welfare accountability systems. He was invited to discuss with administrative staff the possibility of adapting a parallel operational system for the use in a private agency. He believed that it could be done. On this basis, the agency contracted for a relationship that would explore the possibilities of the application of computer technology and programming to JFS's data collection and information system.

There is, in fact, an existing computer program related specifically to the concept of "a case file". This system, known as the "Statistical Package for Social Sciences", was designed in California and subsequently in Chicago to provide sociologists with a way to use computer technology to assist them in their research.

The SPSS program, originally designed in 1965, has been added to, refined and elaborated each succeeding year. The JFS of Philadelphia entered into the SPSS program at the fifth revision of the program. There is now a more elaborate, more versatile system, known as Level Six, to which the JFS program is completely adaptable when it is needed.

At this point, the Executive set forth the operational rules for the implementation of computer programming within the agency. There were -

- 1) No staff person may have employment terminated solely because of the implementation of computer programming;
- 2) the application of computer technology must be acceptable to Board and staff;
- 3) the permanent running costs of a computer system must be within undefined "tolerable" limits.

The first item was the easiest to manage but the most difficult to convince staff of, before implementation. Since the clerical group was primarily affected by computer application, several meetings were held to remind them of the agency's traditional open relations between administrator and personnel.

The issue of acceptability by Board and staff was another matter. All of the

staff had been participants, by design, in the earlier reorganization of the data collection system. All recognized the significant gains achieved by the new system.

When it appeared that computer technology could be used, all the staff members, professional and clerical, suggested how the computer system could be made to give them what they wanted.

The clerical group and the statistician wanted relief from a burden that was increasing geometrically each year as the agency's caseload, number of offices and staff size grew.

The professional staff wanted relief from a system of tallying and counting and adding that took from three to five days to complete.

The administrative staff wanted fast feedback of agency and district performance on a monthly basis. It was possible, as the administrative staff became involved in learning about the computer capabilities and the SPSS program, to be able to project that all of the things that it wished could be delivered.

There were, however, some staff members who felt that the kind of easy "live and let live" days when the agency was a small "family" were disappearing. Many felt that there was too much interest on the part of the administrative staff in accountability and quantification of performance. While this group was not large in number, it was strong in feelings and conveyed to others much nostalgia for the past and trepidation about the future.

Administratively, the only way to cope was to recognize the sentiment and to grant people the right to their own feelings. These feelings were shared by clerical and professional. By and large, however, a new camaraderie grew, developing around the risky joint venture that some of the staff felt they were taking in "making JFS modern".

With the Board, it was another matter. Many feelings expressed by staff were echoed by Board members. Was the agency substituting numbers for compassion? Was

the agency losing its heart? Was JFS becoming too big? Other Board members, based on their own business experience, felt that computer applications meant nothing but more trouble, more headaches and increasing costs. They cautioned the agency against it.

The largest number of the Board however, who, were there through their experience in long range planning, had been asking the questions about agency performance and clientele that the staff had not been able to answer.

The long range planning committee was then asked to formulate the questions whose answers would provide for the Board adequate data to permit it to discharge its obligation of community trusteeship. The long range planning committee took four meetings of two hours each to raise more than 75 questions about the nature of the clients that came to JFS and the kinds of contacts they had had with the agency. When it was pointed out to the committee that each question had a price tag on it in terms of staff time taken to answer it, clerical time to process it, and computer time to tabulate it, there was rapid recognition of the cost of data that the committee had asked for.

The major issue of money costs provided the final stumbling block and appeared as an insuperable handicap. Whatever data was created by the staff would have to be transformed into computer usable punchcards by a keypunch operator. The cost of adding on additional staff person, plus the cost of renting the equipment to translate worker monthly statistical data into punchcard data usable by a computer, went far beyond the financial parameters that were set administratively.

The use of the computer system would depend on programming the computer without an intervening person.

This technological leap was done by using an "Optical Scanning" system. It is possible to use machinery that will translate pencil marks from a sheet of paper into a punched hole on a data card automatically without any human involved in the process.

It called for translating the monthly case list, containing 40 names of the caseload on one piece of paper, into 40 pieces of paper, each with one name. On each "case form" the social worker would list all of his activity for that one case by blacking out numbers or spaces on the form. The approximately 2100 cases that are on JFS's case list every month are transformed by computer machinery into 2100 punchcards in 35 minutes.

Conceptually we have done nothing to alter the classic pattern of the social worker reporting each month what he did on each case. There was no change in the district secretary's or the clerical staff's preparation of case lists or the keeping of monthly accounts of intake, closings and transfers. The intent of the whole system was to create as little discernible alteration in the system and to eliminate or to transform into computer management only those processes which could be best done by computer, i.e. the adding, subtraction, listing and noting of cases entered, transferred and closed in the agency.

At this point, the cost estimates appeared to fall within acceptable limits, recognizing that any increase in technology inevitably carried a price tag with it. However, our consultant believed, on the basis of his past experience, that the agency could have a usable computer system that could be economically feasible.

Since the primary parameter was that no staff person could be terminated from employment, the only costs that could be directly assessed to the computer were those over and above the existing staff functions. For example, the cost of transforming 2100 8 x 11 case reports into 2100 punchcard units costs the agency \$35.00 per month. The cost turning out two computer print-out reports of agency activity listing all intake, transfers and closings, interview count, telephone activity by district and by worker, costs the agency less than \$40.00 per month for a finished computer product.

The cost of printing the optical scanning forms is \$600 per year per 25,000.

To achieve net cost for the forms we deducted the charges formerly paid to FSAA for its specialized reporting forms.

Excluded were the "start-up" costs for errors, "glitches", training and learning expenses, including the cost of the consultant. These costs were not prohibitive and were provided for by special "seed money". The Board and the Executive of the agency had accepted and recognized that the initial cost would have to be amortized over the length of the system which appeared to have a ten to twenty year life span.

The simplicity of the SPSS program, its easy adaptability to social work because of its common root with sociology makes it a usable system that falls within the training and mind-set of family service agencies. Another characteristic of the SPSS program is that it is available in almost every large and medium size city where there is a university that has a computer installation and a social science department. Accordingly, we have no hesitation in recommending the SPSS because of its approach to near universal availability and utility in the United States and Europe.

Because of its versatility, and because it has been paid for many times over, agencies now need only pay for its use rather than for its design. Another positive about the SPSS program is that its widespread use has resulted in many programmers, mostly at the computer centers, who can provide consultation and advice on problems that may occur, and provide direction on further elaborations of the program. There is hardly an agency, we believe, that is not near enough to a computer center using SPSS that it cannot use the program.

The application of the program at JFS operates in the following steps:

- 1) During the first four working days of each month the clerical staff prepares the case forms for the social workers. Each case form includes the case number, its intake status - new, old, recurrent, carried over, transferred - and the social

worker's number to whom the case is assigned. (see diagram)

2) During the fifth and sixth working days of each month, the social work staff completes its monthly case forms, noting on each form the target group, i.e. one-parent families, public assistance client, etc.; number and kind of contacts, and the status of the case for next month - carried over, closed, transferred.

3) All 2100 case forms are collected centrally at the end of the sixth working day and on the seventh working day of each month the forms are taken to the computer center for transformation into punchcards. The punchcards are taken to the computer card-reader. The reading of the program cards and the 2100 punchcards takes 3½ minutes.

4) The following morning either a clerical or maintenance person picks up the printed-out computer reports for agency use. The monthly report forms are destroyed and the cards are kept for one month holdover. They are then destroyed.

5) On the eighth working day of the month the senior administrative staff and each branch director receives a report of what each district office has done in the last month in terms of intake, closings and transfers, an analytic summary prepared by the computer of the performance characteristics of each staff person, and a monthly monitoring of the kinds of cases and problems that are coming to the agency.

In addition to this immediate feedback, staff can communicate directly to the Executive through statistics. This communication is unfiltered, unaltered and unskewed by clerical or statistical staff or sub-administrative personnel. The Executive reports a greater sense of awareness of where the agency is going.

What are the conclusions after one year of successful experience?

1) There is recognition by the staff of the computer system as being an accepted way to gather statistics.

2) The clerical staff who has the main job of preparing case lists and computer

sheets has found its own ways of coping with the preparation so that it does not overwhelm many other assignments.

3) The preparation of the statistical reports for computer management has been so incorporated into, and become part, of the regular day-to-day work load that no new staff was needed to be hired.

4) Because of the savings in clerical time there was need for one less clerical person for the preparation of monthly reports. This redundancy was soon managed by normal attrition so that the extra person filled a vacancy.

The total yearly cost of monthly statistical preparation, including the first year's consultation, printing, clerical time expended, etc. came to \$8000, of which only \$1500 a year represented excess costs over the former system. Because of staff changes and shifts, the economies from that process resulted in a \$10,500 a year saving. The net saving to the agency, including the total prior costs which had always been counted, is a continuing \$2,000 per year net saving.

Total costs for the preparation of monthly statistical reports now are paid for by the overall shift in staff rearrangement and employment and actual savings in staff labor.

The original parameters laid out by the Executive for the implementation of the computer managed statistical system were now met.

- 1) No staff person was terminated because of the implementation of computer systems.
- 2) There was acceptance by Board, professionals and clerical of a computer system as being integral of the agency's operations.
- 3) The costs were within the easily managed levels.

The disadvantages are represented by the problems of the computer itself - its need for accuracy, the rigidity that does not allow staff to spend an extra day completing statistics, the need for scheduling success to the computer and the inevitable staff reaction that occurs whenever a system has qualities of rigidity - a problem that has always been present for social workers.

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK - CASE B

by Dr. Phyllis Freeman

As one reads what transpired at various stages, generic aspects of the planning process emerge. These principles of planning are:

1. Legitimation and sanction must emanate from sources within the organization. In spite of ambivalence at times, the process had the endorsement of the Board and community members.
2. An "orchestrator" must be responsible for the overall execution of the process. The executive administrator fulfilled this role by delineating operation rules for computer use, interpreting the information system to the staff, etc.
3. Objectives must be clear and communicated to everyone in the organization who will be affected. Staff here was actively involved in discussing benefits of the computer and was aware of the Board's request which initiated the process.
4. A factual and accurate benefit/cost analysis is urgent, and time factors considered to compare what is to be gained or lost by innovations. Material was provided which clearly specified monetary savings, reduced manual computations, etc.
5. "Rewards" and "costs" (non-monetary) for personnel should be explicitly communicated and considered an essential component of the planning process. Rewards, such as reduction in manual tasks, should be discussed openly as should negative results, such as reduction in personnel. The non-termination agreement initiated by the executive satisfied lessening the personal threat to employees.
6. Intended and unintended consequences of a major change should be analyzed. Long range planning is in order. For example, if the agency continues to expand, necessitating more computerization, and there should be a new executive, to what degree are employees protected?
7. Alternative plans should be presented so that the merit of the one

finally chosen has been measured against other options. Here, this was done and a suitable system was selected.

8. The organization must identify and retain individuals, outside itself, who have the expertise to assist in formulating viable plans and to render technical assistance. The employment of a consultant from a school of social work satisfied the expertise needed and assured familiarity with the organization, thus avoiding possible value conflicts.

A final review of this case reveals the absence of material on accountability issues governing access, storage, retrieval and destruction of data related to clients and their right of confidentiality. However, the case basically illustrates the successful use of the computer to develop a basic information system.

Questions for Discussion

1. What are the stages of planning? Was it totally a rational process?
2. To what degree does computerization increase "control" aspects?
3. How is communication through statistics likely to alter staff-management relations?
4. What is the impact upon personnel of the innovation covering the life cycle of the computer system?
5. What planning must occur to insure that output data will remain relevant given possible agency modifications?
6. What are staff implications of having workload monitored? Will it be a measure of efficiency and affect promotions, merit increases?

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COMMENTARY FROM THE WHARTON SCHOOL - CASES A AND B

by Dr. Edward B. Shils and Dr. William Zucker

These two cases together make an interesting situation. In case I, the group attempted, on an experimental basis, to develop a quantitative approach to have a monitoring tool for its administrative services. In case II, an agency utilized a computer system as such a tool.

In both instances, the administrators determined some of the vital areas that should be examined so that it was not necessary or desirable to have reams of data pouring into the administrator which either would be meaningless or obfuscating.

In case II, however, the graphing was a technique, but would appear to be a much more inadequate one than the use of the computer and a computer system.

The computer which can only give the administrator that kind of information retrieval that is in the system itself, has, as its greatest benefit, speed and integration of the data in an understandable fashion, which can be programmed for the knowledge and use of the administrator.

In case I, the graphing took time and the method by which the data could be translated into graphs and then used for the evaluative process involves a time-consuming process.

On the other hand, in case II, the data was programmed in such a fashion that the administrator and all of the supervisors had the information retrieved in an almost instantaneous fashion, provided more time for individuals to spend on their program operation and reduced the cost of information gathering and dissemination by an appreciable amount.

Computers, however, and the use of computers are not a panacea, either. It is essential that the administrator know which are the pressure points which bear most vitally on the program and should be watched. These are the early warning signs

which have to be observed and can be observed with rapidity through computer printouts and comparisons against previous results which can alert the administrator and manager to take corrective action or at least to determine why certain situations are occurring.

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CONFRONTING RACISM IN A VOLUNTARY AGENCY

by Miles Overholt, M.S.W.

Within the last ten years, the national council of a large voluntary youth services organization declared that a major national organizational goal should be the eradication of racism within the agency. This goal, encased within the framework of the organization's declaration of priorities, was to be implemented across the country by the organization's local semi-autonomous units. A struggle developed within many of the local units as to whether they would accept the imposed national goal as their own.

Local units, known as associations, are loosely affiliated with the national organization except for a financial obligation. The loose ties are maintained by the structure of the national organization which is subdivided into regions which represent national concerns to the local associations. The national and regional units have no direct authority over local associations, though certification can be denied. Certification requires a yearly payment of one percent of non-grant income to the national body and maintenance of administrative and programmatic standards. After certification, the local association is entitled to use the national emblem and logo. Associations also have access to the resources of the national and regional units, whose staffs are widely used as consultants. These resource persons carry no organizational authority and may or may not be used as the associations deem necessary.

Associations vary in size from small, one person rural units to large, multi-branch suburban/urban units. Regardless of size, each association has the same structural nucleus. A multi-branch unit, usually termed a metropolitan association, will have several branches which are directly accountable to a central metropolitan office. The power and authority of the organization rests with these metropolitan offices. The funds that support the national and regional structure are controlled by the central offices, and key financial decisions, such as withholding national

dues, are made by the executives of the central offices.

Paralleling this professional staff structure is a sophisticated lay structure. Legally, organizational responsibility and authority is held by the lay structure, each association, regional unit and even the national body being a separate non-profit corporation. The lay persons exercise their responsibility and authority through a system of boards and committees, each staffed by an organizational professional (see Appendix). The boards and committees are responsible for budgetary development and control, policy development, personnel administration and program formulation. Staff is responsible for the implementation of the budgets, policies, personnel procedures and programs. The lay structure is self-perpetuated with members selected for their political and financial influence and their interest and knowledge of program goals. Representation of the community and its residents is not a high criterion in the selection process.

This case study examines how one metropolitan association, Middle County, attempts to meet the national goal to eradicate racism. Middle County has two branches, East and West, with the central office located in East Branch. Historically, the association grew from a small operation in East Branch located in a suburban town. West Branch was initially created as the camping branch and, as the surrounding population increased, it developed a full set of programs. Each branch had its own branch executive and local board of managers which were accountable to the executive director and the board of directors. West Branch's executive and board members felt dominated by the central office and believed that their needs and input were often ignored. There was a general resentment of the board of directors and the executive director's liberal attitudes and policies.

The new national priorities and goals were issued just before Middle County embarked upon its own five-year planning process. They served as a focal point for Middle County's planning and were incorporated as local goals. A thorough and

inclusive planning process, involving all staff and laypersons, was created to determine a five year plan and, within this, a training process for all on the critical issues in the organization and community. Some of the training included efforts to affect personal and organizational racist attitudes and behavior. Three different levels of training were used to attack the racism problem- professional staff meetings and retreats; support and professional staff seminars and part-time staff training. The lay structure, throughout the organization, was introduced to the subject through regular meetings and one day sessions focusing on branch problems.

Professional staff development on racism was planned by a representative staff agenda group and implemented by consultants from the region and by the use of a staff person who held a master's degree in social work. Staff attitudes were examined, program content analyzed and racist behavior reviewed by the staff in both staff meetings and retreats. The major emphasis was placed not on attitudes, but on local unit behavior. For example, East Branch staff attempted to examine why Blacks were not using their facilities and the actions that would encourage full Black participation. The branch staff arrived at a list of reasons and agreed to present the reasons and proposed solutions to its board of managers for action.

Professional staff also met with support staff in morning seminars to discuss critical issues facing the association. Racism was incorporated into the seminars, which were againled by the staff M.S.W. The group was involved in a session which led to several support and professional staff members indirectly opposing the racism goal. This opportunity to openly discuss negative attitudes towards minority groups was not exploited. However, a somewhat better intellectual understanding of minority problems and issues was reached and the entire troupe did approve a muffled strategy to deal with racism. The strategy included assigning of professional staff to work with minority teenagers who congregated in the lobby and shifting workloads and responsibility among the support staff to correct for an imbalance in workloads among minority staff.

Part-time staff training was to include segments on racism. Extensive training for part-time staff was held in the summer prior to the opening of the summer camping program. Counselors for programs in both branches participated in a five-day training session which included several two hour segments on racism. The segments dealt with personal attitudes and behavior and cultural differences. Training was done by the daycamp director, staff from the local mental health center and the M.S.W. from East Branch. Role playing and simulated exercises were the primary methods employed. Resistance on the part of many staff members was overtly and covertly expressed during the week of training. However, in the postcamp evaluation, the counseling staff indicated they felt the training was helpful.

The most significant changes were brought about within the lay structure. The goal to eradicate racism was first introduced at the board of directors level and subsequently to the two boards of managers and their committees. Each board and committee was asked by its staff members and its chairperson to appoint a task force to examine the issue. The more liberal board of directors and East Branch board of managers readily complied, but the more conservative West Branch board of managers balked. At the beginning of this process, West Branch laypersons felt that they did not have a racism problem, that minority demands had become extreme, and that once again the board of directors was imposing a policy issue upon them. They were supported in their attitude by the West Branch executive. A slow, reluctant attitudinal shift, in both the executive and the board members, came as the training and discussion took place.

Members of the subcommittees on racism and planning recommended several all day professional staff and lay retreats to discuss planning. Included within these retreats were group discussions on racist behavior and necessary organizational changes. Lay persons led the group and had the responsibility of writing group recommendations. These recommendations were then referred to the appropriate boards

for action. The boards, including a reluctant West Branch board, recommended the adoption of the national goal on racism for the association. Policies were established that directed the staff to:

1. deal with minority vendors and suppliers wherever financially feasible.
2. set goals for the hiring of minority staff, (both part and full time).
3. set up a minority recruitment policy for board and committee membership.
4. mandate program evaluation in terms of minority enrollment.

Certain professional staff members were more able to implement these policies because of their attitudes and organizational function. The West Branch staff was hampered by the attitude of its executive, who like the West Branch board, was unsympathetic to the effort to deal with racism. The staff utilized four strategies to overcome this reluctance.

1. Training sessions, mandated by the executive director, were utilized to confront the West Branch executive with his attitudes. Staff attempted to connect with his negative attitudes and confront his inconsistencies in his approach to dealing with racism problems.
2. Staff implemented a minority recruitment program for part-time staff based on the rationale that federal and state grants mandated a racially representative staff. The program included advertising for staff in local high schools and colleges, with an emphasis on interviewing minority students. This program was hampered by the branch executive failing to allow extensive staff time for recruitment and interviewing. Nonetheless, the daycamp minority staff increased from approximately five percent of the total staff to about ten percent.
3. A recruitment program to bring minority teenagers into the counselor-in-training program was initiated. Local high school advisers were informed of the program and encouraged to inform minority students of its existence and its opportunities. Again this was hampered by lack of allocation of staff time.
4. Local community action programs were encouraged to refer minority youth to the branch programs. As the level of minority enrollment rose, the West Branch executive agreed that staff training on racism would be beneficial and finally directed that it should be included.

In conclusion, two major efforts to confront racism in the Middle County association were partially successful. The first effort, to train staff to examine and change its behavior, resulted in an effort to recruit more minority staff, to expose all part-time staff to racism issues, to encourage greater minority

enrollment and to provide greater opportunity for minorities to enroll in staff training programs. The second effort to have laypersons examine their own attitudes and the organizations behavior had significant results. The lay structure agreed to accept the national goal to eradicate racism as their own, set policies to implement the goal, and implemented a series of retreats to deal with various issues, including racism.

APPENDIX - AGENCY STRUCTURE

Lay Structure

National Board
Representatives from Geographical
Regions
Function-National Policy Making

Regional Board
Representatives from Region
Function-Regional Policy Making

Middle County Board of Directors
Representatives from Total Community
Served
Function-Local Policy Making

East Branch Board of Managers
Representatives from Local
Community
Function-Branch Policy Making

West Branch Board of Managers
Reps from Community
Function-Branch
Policy Making

Program Committees
Review, Evaluate
Programs

Program Committees
Review, Evaluate
Programs

Staff Structure

National Staff
Goal Setting, Image Projecting
Consultants

Regional Staff
Goal Setting, Image Projecting
Consultants

Middle County Executive Director
Administers Local Association
Supervises Branch Executives

*East Branch Director
Administers Branch
Supervises Professionals

*West Branch Director
Administers Branch
Supervises
Professionals

*Program Directors
Administer Specific
Programs

*Program Directors
Administer Specific
Programs

Program Staff-
Run Programs

Program Staff -
Run Programs

Direct supervisory authority

Staffing Relationships (two way accountability)

Indirect Authority

Direct lay accountability

Professional Staff

*

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Sue Henry

The delicate, tenuous relationship between a private agency and its national parent body is one of dynamic tension...creative at best and a love/hate cycle at worst. They need each other, but there is always the issue of local autonomy. Here, there is the added complexity of the relationship between a metropolitan and branch structure.

What are the ramifications of decisions to withhold national support fees? What are the consequences of loss of the agency's charter? What are the implications of the eradication of racism? Of a local decision not to support the parent body's national priorities? What sanctions are available to bring about compliance with service and program priorities and to maintain national support?

Is the appropriate function of a social agency to provide social service and/or to assume community leadership and advocacy positions in social movements?

The staff/volunteer leadership structure is unique to voluntary agencies. An issue is the degree of leadership taken by staff. Without disturbing the delicate balance needed here, could the staff have been more assertive? How? How does the organizational level of a staff member determine his power and influence? What power sources are available in the staff/volunteer relationship?

Strategies to achieve organizational change come under scrutiny. Two important bases for doing this are (1) a professional commitment to change and (2) use of collaboration within the agency. (Patti and Resnick). Clarity regarding the strategies for bringing about change has also been noted (Specht). Is staff development a viable strategy for inducing change? Are there other approaches? Is staff development best achieved through an inclusive planning process or through delegation of the function to a small group? Which factors weigh in the decision and what are the pros and cons of each? How do you feel about using lay persons to lead groups and write recommendations?

If professional competence legitimizes internal change, how is this developed where a staff is more agency-trained than professionally educated? Can a lone Social Worker maintain collegiality, yet be an internal consultant and trainer of peers? What special attributes should a trainer possess, especially in such emotionally charged areas as racism? Which "tactics" of Specht's would you use with the resisting West Branch executive and the Branch board of managers?

What indicators of institutional racism are evident? How do individual racist attitudes become institutionalized into practices? Should an agency hold "correct racial attitudes" as a condition for hiring and job retention? What supports can avoid minority oppression?

In which areas of functioning do racist practices flourish? How might inequities in personnel policies between professional staff and support staff be eliminated? How can there be assurance that suppliers or contractors with whom the agency deals are equitable? How can issues such as equitable hours of operation, fees charged for services, expectation of volunteer time contributed be resolved?

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COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

Racism and human attitudes are hard to eradicate either by ukase or by legislation.

Racism might be confronted, but not be overcome. To do so requires first the commitment and dedication of the executive in charge and also of the board member. This requires more than merely lip service, but truly a demeanor and posture which indicates that a genuine change has occurred in the approach to this problem.

Interpersonal discussions and seminars to identify what exists as racism or personal prejudice is only the first step. Deep seated or sub-conscious attitudes in an individual may or may not emerge in the spoken word or in deed and action, but will come with examples which can be developed in a seminar or a group meeting.

What is far more important, however, is to establish new methods of operation which would correct the past procedures which intensify the racist attitude and point of view.

In this particular instance, there is a most interesting dichotomy between the attitude of one agency branch and how the employees and professionals perceive their executive and board concern for this issue and how the group in the other agency branch perceived it.

The way in which the issues will be resolved, the attempt made by the executive and the board to take the needed corrective action both with respect to changing policies and operating procedures, employment and training of minority personnel in order to attract minority clients and also to have an approach toward the minority community all are designed to develop a new attitude toward the minority community. In so doing, it may not be possible to eradicate a racist point of view, but at least it will put a new emphasis or a new approach upon the program of the organization and in so doing develop a point of view which eventually may eradicate the racism in the minds of the professional staff and the board.

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MANAGEMENT BY OBJECTIVES

by Victorina Peralta

I. BACKGROUND MATERIALS

Adult & Aging Services, a Division of the Philadelphia Department of Public Welfare, is primarily a Protective Service Agency that serves approximately 16.7% of the total population of Philadelphia from age 18 and up.

As a Protective Service Agency, it provides supportive counseling, guardianship, nursing home placement, emergency placements, homemaker services, and adult foster care.

It receives state funding on a 75/25 basis (75% state and 25% city) for those eligible under the grant program. Aside from this funding, the city provides 100% funding for those individuals 18 years and up who do not meet the eligibility criteria under the grant program.

Hiring and firing of staff are controlled by the Civil Service Regulations and contract with the labor union (Council #33 and Council #47).

II. STATEMENT OF THE PROBLEM

The year 1973, and up to the summer of 1974, was a bad year for Adult and Aging Services Division. It was filled with problems, tensions and anxieties as its services took a nose-dive and its public image as a service agency sank to "rock-bottom". The Monitoring Report of the County Board of Assistance, as well as the Evaluation Report of Temple University School of Social Policy were both full of questions as to the effectiveness and usefulness of Adult and Aging Services Division as a social service agency. Both reports called attention to the extreme lack of organizational structure, defective service delivery system and highly questionable statistics.

This, in effect, made the State Department of Public Welfare, Office on Aging, both at the Regional level and State level, scrutinize Adult and Aging Services.

For a while, the question of "Should Adult and Aging Services continue to receive state/federal funding?" was contemplated.

This case study is written from the point of view of the Director of Adult and Aging Services.

III. FINDINGS.

In October 1974 a new Director, hired by Adult and Aging Services, took a microscopic examination of the Division and identified the following problems in depth:

1. Staff morale was at its lowest ebb due to unreasonable strictures.
2. There was no well-defined organizational structure.
3. There was no systematic communication flow with, among, and by staff at various levels.
4. There was a lack of incentives.
5. A lack of public trust and confidence in the Division.
6. Staff training and development was not routine.
7. The Division was operating "isolated" from the community.
8. There was extreme understaffing.
9. Clear cut policies and working procedures were lacking.
10. Knowledge of community resources and how to relate with them effectively was inadequate.
11. The teamwork approach was alien to the Division, as each service unit was operating on its own.
12. Case records were poorly kept, duplicated, even triplicated, and at times totally lost.
13. The physical setup located some of the staff on the 8th floor and the rest on the 19th floor.
14. The crisis oriented social work approach was being employed, and Band-aid social work was being rendered.

Thus, services produced little and/or no impact in the lives of clients being

served by Adult and Aging Services Division.

The above self-examination and findings further confirmed the evaluatory reports previously mentioned.

IV. ACTION TAKEN

The new Director of Adult and Aging Services had had prior experience in using the process of Management By Objectives to create and manage a new department within an agency. The results were quite successful, which she attributed partially to the fact that the workers in that agency were very committed. The Director came to the Department of Public Welfare planning to implement MBO and to discover if it would be successful in this setting with perhaps less motivated, but more knowledgeable workers.

MBO was seen by the Director as an enabling force which would stimulate incentives and provide opportunities for new challenges. With this philosophy in mind, MBO was implemented on October 15, 1974.

V. METHODOLOGY

Step I: Climate Setting

The philosophy and concept of MBO were explained and discussed with the Unit Supervisors concurrently with the Social Workers in detail. Three training sessions for the total staff were held in order to explicate the following ideas:

1. MBO is a systems approach to managing which encompasses the entire organization.
2. Those accountable for directing the organization first determine goals to be achieved during a particular period.
3. MBO requires, permits, and encourages all key managerial and administrative personnel to contribute their maximum to achieving the overall objectives.
4. MBO blends and balances the planned activity of all key personnel towards realization of the mission of the organization as a whole.

5. This process provides a control mechanism to monitor progress, then reports results to those accountable at all levels.

The purpose of Step I, the "link-pin" approach, is to get the input of all workers. It creates a climate of teamwork, and provides the substance of MBO.

Step II: Setting of Objectives

In preparation for setting the objectives, the differences between MBO and "The Way We Used To Do It" were explained and analyzed in detail by the Director with supervisors and social workers. There were thirteen identifiable differences, which were:

1. Organizational priorities are determined.
2. Realistic objectives are set.
3. Each worker has objectives.
4. Each worker plays an active role in setting objectives.
5. All objectives are blended into the total plan.
6. Plans are developed to achieve objectives.
7. Plans and objectives are pursued on a will do basis.
8. Emphasis is on motivational objectives setting; not fiscal.
9. Each worker receives feedback on his performance.
10. Decentralization of decision making takes place.
11. Clear and decentralized authority is granted.
12. The need to know communications is highlighted.
13. Managing takes priority over controlling.

The purpose of Step II is to fully understand the concept and philosophy of MBO in relation to social work supervision - this is the "why" of the MBO.

Step III: Developing the Goals

During this session, the Director, with the input of supervisors and social workers, jointly developed the criteria for effective goals. The criteria developed

and used are as follows:

1. Specific - Results, not activities which are supported by plans to achieve.
2. Measurable - To the maximum extent practical, the goals must be measurable.
3. Realistic - Attainable and revised if necessary.
4. Stretch - Above normal effort.
5. Match - Experience and capability.
6. Consistent - With responsibility and authority.
7. Compatible - With departmental and overall objectives.
8. Clear - Understood by the Director, supervisors, and workers.
9. Priority - Matters arranged according to priorities.
10. Change - From one target period to next.
11. Written - In terminology clearly understood by worker and supervisor.
12. Wording - No set formula or style.
13. Recommended - by Subordinate - Maximum participation practical.

The purpose of Step III is to provide the "how" of MBO.

Step IV: Implementation

During this session, each service unit formulates its unit goal to relate it to the total agency goal. Then each worker within a service unit does the following:

1. Clarifies responsibility with supervisor.
2. Reaches agreement on "key results areas" within worker's responsibility.
3. Recommends and reaches agreement on objectives within worker's responsibility and key results areas.
4. Recommends and receives approval on worker's plans for achieving the objectives from supervisors.
5. Recommends and reaches agreement on the authority worker will require.
6. Insures the receipt of feedback.
7. Reviews performance vs. objectives with supervisor on a monthly and yearly basis.
8. Revises objectives and plans as necessary.
9. Steps 1 through 8 are repeated each year.

The following report is a sample monthly MBO plan which workers submit to Unit Supervisors. The narrative and statistical components of the report describe both the quantity and quality of the worker's monthly progress.

MODEL MBO REPORT

Goals for March

1. My goals had been to increase number of contract forms completed to at least 15.
2. To make at least 33 home visits.
3. To make contact with all clients referred to me within one week from date of referral.

Progress

I succeeded in completing 15 State Contracts for March. Regarding home visits, only 26 clients were seen in the field. With the exception of two clients, all others referred to me were not visited within the time limit I set as my goal.

Diagnostic Thinking

The goals I set for March seem reasonable and appropriate in retrospect. I reached my first goal and am pleased about that. I nearly reached my third goal and feel satisfied about that. The second goal was my most ambitious. I did not reach it because I had two vacation days plus a holiday during the month. I also spent most of the day training a new worker. All this occurred during the latter part of the month, thus disrupting my field schedule which, up until then, had been on target.

Goals for April

1. To increase number of contract forms completed from 15 to at least 18.
2. To increase number of field visits made from 26 in March to 33 in April.
To call or visit all clients referred to me prior to January 31, 1975.

VI. Difficulties in Implementation

The greatest resistance came from supervisors, who complained of a lack of time for the extra paperwork and meetings with workers. MBO revealed the lack of organization and structure and the crisis oriented nature of the supervisory process. The Director showed how MBO would improve the supervision by enabling the Division to develop long-term planning and structure. She also mapped out the number of working hours in the supervisors' week, thereby, describing how time could be allotted for the extra work.

Initially, the Director had to alleviate the supervisors' anxiety about the first part of MBO which called for workers reporting to her instead of to them. She explained that this would happen in the beginning while the workers were learning MBO. She also explained that she would be sending a copy of each worker's monthly report, with her comments, to the appropriate supervisor so he or she could be aware of the Director's comments and criticism of worker. The Director feels that the supervisors now see how MBO had benefitted both the working structure and the clients.

VII. Impact

As a result of using the MBO process the Director sees the following accomplishments by Adult and Aging Services:

1. Staff morale has improved.
2. The teamwork approach has been instituted and is functioning effectively.
3. The agency structure has been organized and solidified.
4. Social services are being rendered in lasting and meaningful ways using the holistic approach.
5. Working policies and procedures have been developed and are being implemented for the maximum benefits of clients.
6. An internal (In-Service Committee) and external (Advisory Board) advisory network have been established.
7. There now exist more effective avenues of communication and feedback with and among staff at all levels and with the total community. Improvement is still needed in this area.
8. There exists an on-going staff development and training program which insures current knowledge and skills for all workers.
9. Rapport has been established with outside agencies.
10. Adult and Aging Services has expanded its services to include outreach (Project: HEAD), Friendly Visiting, Advocacy, Community Forums, Community Involvement Services and Student Placement (Schools of Social Work).

Adult and Aging Services accomplished the above in nine months (October 1, 1974 - June 30, 1975). These accomplishments were achieved through the support, cooperation, hard work and dedication of the staff at all levels using MBO as a tool. However,

other new problems now remain to be solved!

VIII. Adapting MBO to a Non-Profit Organization

To the Director, the biggest drawback of MBO is the authoritative approach, as it is traditionally used in a profit setting. She believes that in human services, it is not beneficial to the agency to demand a certain amount of work. The human aspect and quality of work must be preserved simultaneously with organizational and professional development. The Director wanted to maintain the social work value of working with staff members and their making group decisions. To do this, the workers reviewed the first MBO reports submitted and chose one to use as a model in terms of the number and quality of home visits. By using this procedure, the workers served to motivate and structure themselves instead of the Director placing strictures on them.

The Director chose a number of workers who had higher quality MBO reports to form an "in-service advisory committee", to serve in an advisory capacity to the Director and to the other workers.

In a non-profit setting, MBO is seen as an enabling rather than controlling method. Social workers are given freedom and the responsibility to use that freedom to benefit their work and their clients.

One benefit of MBO for social workers is that it enhances the ability to separate personality from quantity and quality of work when evaluating a worker. MBO enables the evaluator to be objective in viewing the worker.

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Sue Henry

Management by Objectives (MBO) "is a participatory form of management through which staff may contribute to the direction of its immediate department and the entire agency by writing plans and goals which relate to the organization's mission and objectives." (Wiehe 1974)

Criticism of this procedure focuses on the commitment required, necessary time and effort, the cost, the probability of success and the effect on the agency. (Raider 1975)

In this case, the following questions and issues emerge:

1. Did the Director observe Wiehe's method? How might MBO have been set within a participatory management framework? Were the work plans and goals related to the objectives? If they were attained, would the objectives be achieved? How do you know? Were the final changes identified by the Director congruent with the initial problem definition?

2. Did the Director address the concerns raised by Raider? What indicators did she use to insure that these concerns were considered? How were the impact measured and the results evaluated?

3. The Director entered the Division new, in a fashion resembling the entry of a consultant. The stages of the consultation process, a useful formulation for the case example, are as follows:

- a. Recognition and statement of the problem.
- b. Ability to quantitatively evaluate the problem's gravity.
- c. Knowledge of the relevant cause and effect of relationships.
- d. The formulation of alternative solutions.
- e. The selection of a particular alternative.
- f. Putting selected alternatives into effect. (Tilles 1961)

The Director needed to understand the Division's functioning, dynamics and structure to proceed with an MBO system as an alternative to "The Way We Used To Do It." What elements would she have to look for? Are these the elements any consultant would

observe, whether entering as internal or external to an organization? What risks did she take in initiating MBO? What indicators would she have seen, and what predictions made, in deciding to implement MBO in the new setting? Was the Director a consultant here?

4. Traditionally, supervision has been asked to carry as many as five different roles in social work: administrative, educational, therapeutic, secondary leadership and managerial. Is this appropriate? Which roles seem appropriate when seen from a management perspective? What are the characteristics of that form of personnel administration? What analysis and information lead to the conclusions reached regarding appropriateness? (Watson 1973)

5. The pressure for accountability, regarding work planning and performance, comes increasingly as an external need; frequently it is perceived by managers as an external restraint as well. Here, there may have been an external need for greater accountability; however, it was seen by the Director as an internal need. When MBO is used for personnel control and is tied to accountability, external or internal, what becomes of other functions of personnel administration?

6. Did MBO here sufficiently address the external relationship issues? Are external considerations balanced with internal needs? Do improved staff morale and internal operations necessarily lead to improved external relations and productivity?

Related Readings

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COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

Management by objectives has been paraded as a panacea of the management process. It has been suggested that one should establish goals, allow subordinates and supervisors to provide inputs and have inter-personal discussions and thus out of it will come better understanding, high morale, and greater productivity.

Some of these results have indeed occurred. But it requires dedication, commitment and leadership by the executive/manager. It also calls for a group of employees trained in achieving the results. Finally, it takes patience and time to achieve the goals and results desired by the process.

MBO is not another Stakhanovite attempt to increase productivity. Through better morale, goal setting established through discussion and consensus and an understanding of the role and purpose of the agency, MBO can achieve better results for client or consumer - and in the business world, higher productivity.

MBO establishes goals which management and employees can agree upon. As a result, management and the individual employee have a measure against which performance can be evaluated. It is here that MBO can be most effective.

Evaluation of individual performance must be on a regular basis with frank appraisals through conferences between supervisors and employees. This is a time consuming process taking time from program implementation. The time spent is jealously guarded and resented by the administrators and employees as an intrusion on an already busy and harried day.

Proper use of MBO demands that employees be commended and rewarded for achieving the goals (assuming that they are set each time for greater achievement than the individual's norm). Reward may require salary or compensation change, increases in responsibility or changes in title and duties. All this may force the administrator into fiscal turmoil which is unanticipated.

Similarly, if the evaluation shows that the goals have not been met, a program must be installed which will aid the employee in achieving them. If this is not successful, the supervisor takes corrective action.

MBO is not a self-operating device. It requires active participation by all those involved.

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RESOLUTION OF ORGANIZATIONAL CONFLICT

by Mrs. Elizabeth Scattergood, ACSW

Setting

The Children's Unit of a psychiatric facility, offering out-patient and in-patient care as well as a therapeutic school. The professional staff of the facility also provides a training program for twenty-five trainees of various disciplines.

Time of project: May 1975 - Jan. 1976 (project is now near completion).

At a Children's Unit administrative meeting, attended by staff members and trainees of all disciplines, chronically felt dissatisfaction surfaced regarding poor attendance at intake conferences. These bi-weekly case conferences serve a double purpose: 1) they review the diagnostic findings of the intake study, and define the appropriate treatment approach and 2) they serve as a teaching medium for trainees in the disciplines of psychiatry, psychology, social work and art therapy. Attendance, which is supposedly total, has been poor. Those who do come regularly - mostly "old time" staff members and social work, psychology and art students - grumble at the "lack of involvement" of the non-attenders, especially the psychiatric residents. The latter protest that they are too busy, and also that the material is repetitive and boring. This particularly applies to the social worker's background material on the family which the residents find too detailed and less than electrifying.

Since this dissatisfaction had existed for some time, it was decided in the May administrative meeting that a task force would look into these problems and be prepared to report back to the full staff the following month. The task force committee consisted of representatives of psychiatry, psychology, social work, nursing, art therapy and the school faculty. It was interracial in composition.

The chairman was a supervising psychiatrist, appointed by the director of the children's unit. While he was not "elected" as chairman, he was felt by all to be a suitable choice, because of previously demonstrated concern with clinic morale.

Early in its sessions, the task force identified that the non-attendance at intake conferences was not a simple, delimited problem. On the contrary, it seemed symptomatic of blocked and uneasy interdisciplinary relationships which appeared to be related to, among other things:

- 1) The clinic philosophy, which needed re-defining. Twenty years before, when the children's unit had opened, the philosophy had been built clearly on a child guidance model; it had gradually become more and more psychoanalytic; later family therapy and community psychiatry had entered the scene. These changes had been gradual and partial. They were further complicated by trainees who came with a wide variety of interests and expectations. We now found ourselves in a setting in which mixed and unclear philosophies were leading to mixed and unclear team relationships and at times to discordant treatment approaches.

- 2) Among the disciplines, role changes had occurred over the years, again gradually enough to escape official re-definition. In the beginning, the medical model had full sway. Psychiatrists treated, psychologists tested, social workers did case work with parents, and art therapists did not even exist! With no competition among disciplines, mutual respect was spontaneously and freely accorded. As times passed, psychiatric residents were assigned some parents, to learn that aspect of child guidance; psychology interns wished to learn therapy and began to treat both children and parents; social workers, (at first only very experienced ones) then later social work students as well, began to treat children, as did the art students when they began their affiliation with our program. As these changes happened, urgent requests began to be voiced that all disciplines should be given access to seminars in which treatment methods were being taught - seminars previously

open only to psychiatric residents. In addition to the interest the other disciplines had in developing treatment skills, a practical consideration furthered this trend: there were not enough psychiatrists and residents to do all the treatment needed, and unless the other disciplines helped, many children would go untreated. (All treatment done by trainees, is of course, very closely supervised). This trend to have all disciplines participate in treatment had led to a blurring of roles among the disciplines, with consequent occasional rivalries and resistances. (eg Some residents were not happy about sharing their seminars with non-medical trainees.)

The philosophy of the clinic and the blurring of roles were two of the several issues which emerged in the early task force meetings as underlying the intake conference attendance problem. The committee believed that to supply simple solutions to an unclear problem would be an evasion. Therefore, instead of reporting back to the staff after a month, it decided to ask for a meeting with the department heads committee. At that time, the task force reported that deeper issues were being unearthed that would require many more meetings to understand, and a longer time limit was requested. The thinking to date was shared, and since several of the department heads had been with the clinic since the beginning, some historical perspective was requested and received. Also, one of the department heads (Director of Social Service) was asked to join the task force in its subsequent meetings.

The task force then continued meeting weekly throughout the summer and fall months. The decision was made to handle the assignment in four phases:

Phase I To identify problem areas in the children's unit, and in so far as possible, determine the causes of them. If promising solutions occurred to any of us, they would be noted and set aside for later consideration.

Phase II A written report on the above would be shared first with the Children's Unit Director for his information and input. (This was done in Dec. 1975). Then it

would be shared with an administrative meeting of the total staff.

Phase III Following thorough discussion with the staff and trainees, their contributions would be included in the further deliberations of the task force. The revised report of the task force then would include:

a) A description of the state of the children's unit, its problems and their causes, based on information distilled from the contributions of the director, staff members and trainees as well as task force members.

b) The recommended changes, also based on the input of the above persons.

Phase IV Final presentation of the report to the staff. At this time, those measures deemed helpful in improving interdisciplinary relationships would be adopted.

It was the belief of the task force committee that if the underlying confusions and discomforts are addressed, the attendance at intake conferences would no longer be a problem.

EPILOGUE

At this writing, we are in the midst of Phase II of the procedure we are following. Although the project is unfinished, it is not too soon to say that this approach has had value for us. As members of an interdisciplinary team, we have been required to share openly and deeply our dissatisfactions and appreciation. The relatively small problem of non-attendance at staff meetings might have been handled by an order from the director that attendance is required. However, by the method we are using, the subtler and deeper implications are being dealt with, and we believe that the whole atmosphere of the clinic will become more functional and cooperative as a result.

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Elisabeth Schaub

The administrators of this Unit in a psychiatric facility become concerned, first, about remedying the floundering and flagging staff conferences. They soon realize that these difficulties are symptomatic. Changes in the total organization's clientele, domain, goals, and technology have created degrees of role ambiguity, conflict, and low morale among the interprofessional staff. Redefining program objectives, staff roles and duties, and the authority structure need to be directly addressed. The "how" and "why" of this innovation process needs consideration.

Questions to Consider

1. What factors, often found in medical, interdisciplinary settings, weaken the coordinated treatment of teams like this?
2. Evaluate utilizing the task force as a means for conflict resolution. Would a different vehicle for conflict resolution be preferable or not? Why?
3. How do you anticipate a staff reassessment of program objectives, initiated by the administration of the Unit, would be received by the professionals with mutual responsibility for Unit services?
4. What changes, external to the Unit, in the organizational environment of the total psychiatric facility need to be reconsidered by the Unit staff as part of a reassessment of their treatment objectives and methodology?
5. What bureaucratic changes in the Unit are needed to clearly establish the reciprocal authority and duties of the professionals on the treatment teams in relation to the clients and to the Director and other administrative staff? How would you implement these changes to gradually bring about more effective interprofessional coordination of treatment? What initial innovative measures might minimize the negative impact of changes on the staff and on their service delivery?

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COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zuckerman

In a business situation, job descriptions would be written to try to define the specific duties and responsibilities of each of the individuals involved in an organization.

In this situation, each profession has a hand in the therapeutic treatment of the patients or the parents and there are disparate relationships and responsibilities throughout the organization. Leadership and organization are called forth--with direction as to who will perform which functions and under which circumstances.

At this point, everyone in the organization appears to be a cook and there is little or no direction given to the total organization. Organization design appears to be called for with each professional group needed to report to a supervisor and, through the supervisor, to the director of the children's unit. Supervisors then can assign attendance at the weekly conferences. Perhaps, not all need attend each conference and the conferences would be structured in a fashion which will develop these sessions as teaching and professional experiences rather than as "bull sessions." The supervisors would then be responsible for the training and professional development under the direction and design of the executive director.

Exorcising frustrations or airing differences may ventilate some of the disagreements. But a more basic problem than the attendance at the weekly staff meetings is how each professional relates and is integrated into the program and operation of others. That is determined by goals, objectives and organization design.

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MR. BURNS' PROMOTION DILEMMA

by John M. Whiddon

William Burns is Bureau Chief in a Staff Division of a major department in state government. Throughout his 17 years of dedicated public service, he has established the reputation of being a perfectionist demanding quality work from his staff. His personal and professional integrity has never been questioned. He has been working in his present position for only a year and a half, while most of his staff have been there at least two years.

His primary management responsibilities center around the deployment of nine individual professional personnel, at the Master's level, who were chosen by a prior administrator for their specific expertise, resourcefulness and ability to withstand pressure related to rigid work review. The work performed by his Bureau encompasses special planning assignments generated by the Office of the Secretary, technical assistance requests from Division Directors, and in-house projects as suggested by individual staff.

The primary mission of the Bureau is to develop comprehensive service delivery systems proposals and to prepare plans related to integrated service delivery.

The magnitude of bureau responsibilities has resulted in Mr. Burns' delegation of major areas of responsibility to each of his staff, with little differentiation as to complexity of assignments. In doing this, Mr. Burns has relied on the judgment and initiative of his staff, and in many instances he has had to let them decide on specific policy determinations or interpretations without review or consultation from him or anyone else in the Bureau. Mr. Burns feels that he has nine competent professionals, but he also realizes that they have different personalities, different expertise, administrative styles and pay grades.

Traditionally, there has been little staff turnover in the Bureau. Since the Bureau was created, three years earlier, there have been only two positions to fill. One of these positions is now vacant.

Although there are three different classifications of planning positions in the Bureau, each professional planner functions as an individual rather than in any kind of team concept. Each is accountable only to the Bureau Chief.

For some time, Mr. Burns has observed that his Bureau is suffering from a morale problem. It appears to result from the unfilled promotion position, which has existed for five months. Mr. Burns' procrastination has caused anxiety and paranoia since it is well known that it has been his past policy to promote from within. There are several reasons for his delay. (1) He wanted an opportunity to observe each of his three eligible personnel. (2) He wanted to save salary to provide larger merit increases for all Bureau secretaries. (3) He has been developing a new management pattern for his Bureau and did not want to appoint anyone until he determined the specific functional responsibilities for the job.

However, Mr. Burns has just received word from the Divisional Personnel Officer that he must either fill the position or possibly lose it. It has been pointed out that freezes will be put on positions that are not filled prior to March 1, 1975, which was only one week away. It was also pointed out "that" if he chose not to fill the position another Bureau within the Division might have the option of taking personnel action known as "add and delete" which would remove the line from the bureau budget permanently.

Mr. Burns knew that the pressure was on. Major assignments and task force committees had prevented him from observing his eligible staff as he had initially hoped. He had not been able to fully develop his new management pattern. But he had no intention of losing his line on a temporary or permanent basis. A decision had to be made within the week.

Mr. Burns determined that he would evaluate each of his three eligibles in terms of: (1) objective criteria, (2) subjective criteria, (3) unique or extenuating criteria. In addition, he decided to utilize his top three staff personnel for

the evaluation of subjective criteria to reduce any personal bias. Although the new management pattern did not exist, Mr. Burns had an idea of the general responsibilities that would be required. With the criteria and requirements in mind, Mr. Burns began his analysis and selection process.

The first action Mr. Burns took in the analysis and selection process was to review the job description for the position he needed to fill. It read as follows:

PLANNER AND EVALUATOR I I - HRS

DISTINGUISHING CHARACTERISTICS OF WORK

This is responsible planning and evaluation work in developing and evaluating health, rehabilitative and other social service plans and programs.

An employee in a position allocated to this class is responsible for planning, coordinating and evaluating activities in a moderately complex functional area of health, rehabilitative and social programs. Duties include assisting in the definition of departmental objectives and stating these objectives in measurable terms; planning and developing comprehensive programs to meet departmental objectives; assisting and coordinating other divisions in planning and developing their programs to meet departmental objectives; and assisting departmental planning task forces charged with planning new or revised programs.

Work is performed under the general supervision of a higher level employee and is reviewed through periodic conferences and written reports.

EXAMPLES OF WORK PERFORMED

(NOTE: These examples are intended only as illustrations of the various types of work performed in positions allocated to this class. The omission of specific statements of duties does not exclude them from the position if the work is similar, related, or a logical assignment to the position.)

Consults with divisional planning personnel, Department of Administration personnel and private agencies.

Evaluates program performance in light of stated objectives and future trends, development and opportunities.

Projects current and planned programs into the future to determine needed changes and develops alternatives and assesses their consequences.

Evaluates programs that cross inter-divisional and inter-departmental lines to identify gaps of coverage, overlaps and failures to respond to the needs of client populations.

Prepares and maintains accurate reports and records describing planning and evaluation activities in the assigned area of responsibility.

Performs related work as required.

MINIMUM TRAINING AND EXPERIENCE

Graduation from an accredited four-year college or university with

major course work in planning, business or public administration, education, public health, social work, government or one of the social sciences and three years of progressively responsible related experience in planning or a health or rehabilitative program.

A master's degree in social work may be substituted for two years of the required experience.

A master's degree in planning, business or public administration, education, public health, government or one of the social sciences may be substituted for one year of the required experience.

Successful completion of college course work in one of the above areas past the master's degree level may be substituted for a maximum of two years of the required experience on the basis of 30 semester hours for one year of experience.

A doctor's degree in one of the above areas may be substituted for the required experience.

Mr. Burns then reviewed the promotion roster from the Department of Administration, Division of Personnel. He was obligated by state law to hire, from the top, five eligibles on the register. Although there was a personnel maneuver around this requirement, Mr. Burns had never used it nor did he intend to use it. In reviewing the register the following information was revealed.

All three eligibles were in the top five on the register

1. Mr. Johnson with a score of 95.
2. Mr. Harvey with a score of 91.
3. Mrs. Ramsey with a score of 90.

Mr. Burns then developed a staff profile on each which he obtained from the bureau personnel files. He utilized this information to construct a personnel matrix. It looked as follows:

	<u>AGE</u>	<u>TIME WITH DIVISION</u>	<u>STATE TIME</u>	<u>DEGREE</u>	<u>DEGREE AREA</u>	<u>AV. EVAL. RATINGS</u>	<u># OF RATINGS</u>
Mr. Johnson	29	2 yrs.	2 yrs.	M.A.	Soc. Work Admin.	Outstanding	3
Mr. Harvey	42	3½ yrs.	14 yrs.	B.A.	Pol. Sci.	Excellent	6
Mrs. Ramsey	40	3 yrs.	10 yrs.	B.A.	Nursing	Outstanding	5

The next step was to call in each of his three top level employees for their input. He obtained very little help since each of them had a different first

choice. Their individual assessments were as follows:

	<u>1st Choice</u>	<u>2nd Choice</u>	<u>3rd Choice</u>
Mr. Bishop	Mr. Johnson	Mrs. Ramsey	Mr. Harvey
Mrs. Tool	Mrs. Ramsey	Mr. Johnson	Mr. Harvey
Mrs. Winters	Mr. Harvey	Mr. Johnson	Mrs. Ramsey

Mr. Burns then attempted to accomplish a subjective assessment of each of his eligibles. These were his thoughts:

Mr. Harvey- Mr. Harvey and Mr. Burns were about the same age and they mixed socially on occasions. Mr. Harvey had a variety of state government experience, and Mr. Burns felt he could rely on him to do anything he asked. Although Mr. Harvey was not Mr. Burns' most creative employee, he was his most dependable. Mr. Harvey showed a common sense approach to problem solving that often cut through unnecessary verbiage. Mr. Burns was very fond of Mr. Harvey and felt that his loyalty was unquestionable. At times Mr. Burns had been concerned with Mr. Harvey's eternal pessimism although he had never made any attempt to deal with it. Mr. Burns had perceived that several of the staff and secretaries did not seem to like Mr. Harvey, which he assumed was due primarily to age differences and unrelated social interests. Mr. Burns also thought about Mr. Harvey's wife and four children. He felt that this promotion would probably be the end of the line for Mr. Harvey's career. Because of Mr. Harvey's age and the emergence of more trained and qualified individuals, it would be difficult for him to compete the next time around. He wondered how Mr. Harvey would react if he were passed over for a younger individual with less seniority and overall experience.

Mrs. Ramsey - Mr. Burns genuinely liked Mrs. Ramsey. He had always taken a great deal of interest in her output since she was the only minority member on the staff. He had, on several occasions, received compliments from the highest echelons in the Department regarding her work. Mr. Burns' chief concern was that Mrs. Ramsey did

not express herself very openly, even if discussions centered around her area of expertise. Mr. Burns realized that Mrs. Ramsey was basically shy, and that she had a tendency to back away from controversial issues. She would overcompensate by plowing into volumes of work to produce written overkill for things that she wished to promote.

Mrs. Ramsey, because of her unique background and experience, had an expertise that was shared by no one else in the Bureau. Her persistence in doing routine work as well as complex assignments was admired by everyone.

Mr. Burns was also aware that Mrs. Ramsey had been given an educational leave with pay which would begin in about four months. She would be attending graduate school to obtain a master's degree in social work with an emphasis in planning and administration.

Although Mr. Burns was under no pressure through affirmative action, he was personally committed to implementing such a policy in his Bureau.

Mr. Johnson - Mr. Burns viewed Mr. Johnson, his youngest and newest employee, with respect. He felt that Mr. Johnson had the potential for becoming the most well rounded professional in the Bureau and maybe even the Division. Mr. Burns had taken a personal interest in Mr. Johnson's talents and had often taken him aside for special "tricks-of-the-trade" consultation. Mr. Burns' primary concern was that Mr. Johnson tended to be a little too idealistic at times and might become disillusioned with bureaucracy before he could be turned on to the payoffs associated with Process. Mr. Johnson was extremely creative and gave the impression of having more self confidence than anyone in the Bureau. Mr. Burns had also observed that Mr. Johnson had a way of dealing with people that made them respect and like him. He was probably the most liked individual in the Bureau by staff and secretarial personnel as well.

The final step in the process consisted of listing some basic assumptions and

analyzing three separate options and the consequences of each.

The basic assumptions were that:

- All three of the candidates were capable and qualified.
- Any one of the three could be promoted legitimately without fear of personnel grievance action
- Affirmative action was not an issue in this Bureau
- Seniority had not been set as a precedent for promotion
- Whether or not a person had applied for leave of special assignment had nothing to do with his right for promotional consideration
- A bureau chief has the responsibility for making decisions that are in the overall best interests of his work mission
- A bureau chief has the responsibility for promoting the career development and progression of each of his employees.

Option 1 - Promote Mr. Harvey

If Mr. Burns promotes Mr. Harvey, he sets an immediate precedent of promoting from seniority. He also suggests that a Bureau chief values age and experience more than qualifications and versatility. He also indicates that although he has listened to his staff he has chosen to ignore their overall input. Finally, he has given the impression that a person's ultimate career development and profession is immediately more important than is the immediate or short term need of the Bureau.

Option 2 - Promote Mrs. Ramsey

Mr. Burns feels that if he promotes Mrs. Ramsey he will have done more than his share for affirmative action. He also feels that he will not be establishing a precedent of seniority. In addition, an action of this kind will strike a balance between versatility and dependency. On the other hand it will not be especially good for morale if she is promoted and leaves the Bureau for school.

Option 3 - Promote Mr. Johnson

Mr. Burns feels that if he promotes Mr. Johnson he will not be establishing a precedent of seniority and will be taking into consideration the recommendations of

of his senior staff. On the other hand, it may appear to many in the Bureau that he is playing favorite and values academic qualifications more than age and experience.

Option 4 - Select Another Candidate From The Top Five In The Register

If this option is taken Mr. Burns will move away from his precedent from promoting from within. If this decision is made, it might create other unpredictable consequences and do little for existing staff morale. This decision would also deny career development and progression to all three eligibles in the Bureau.

Given the presentation of the aforementioned factors, Mr. Burns is at the point of having to make a decision. Without knowing the final outcome, what do you think Mr. Burns will do? Why? What would you have done in this situation? Give the rationale for your actions.

COMMENTARY FROM THE SCHOOL OF SOCIAL WORK

by Dr. Phyllis Freeman

The central problem, the lack of a formalized process for staff development and promotion, results in the peripheral issue of "span of control," and leads to a decision-making process that is highly subjective, depending almost totally, upon the judgments of the executive. Dangers here may be executive favoritism toward those who are similar in leadership, style and personality and the question of promotion based on seniority.

It is generally agreed that "management should stress competence above seniority in promotion." Studies indicate that ignoring this principle can adversely affect efficiency and morale. Seniority is a valid criteria only when employees have equal qualifications.

Should one promote from "within" or "outside?" Promoting from within can provide motivation and result in greater productivity. However, "inbreeding" can stagnate innovation and creativity. Promoting from outside can be detrimental to staff which perceives that only "outsiders" are likely to fill key positions. However, open competition permits consideration of the best qualified candidates.

Koontz and O'Donnell suggest:

1. Principle of staffing objective--Objective of managerial staffing is to assure that positions will be filled by able and willing personnel.
2. Principle of staffing--A clear definition of organization roles, their human requirements, and techniques of manager training and appraisal result in better managerial quality.
3. Principle of job definition--The more precisely are known the results a manager is expected to attain, the more the parameters of his position can be deduced.
4. Principle of managerial appraisal--The more specific the management results intended, the more closely managers should be appraised in their terms.
5. Principle of open competition--The more an enterprise is committed to quality management, the more it will encourage open competition among all candidates for management positions.

6. Principle of management development--The more that development programs aim at improving managers' abilities, making them promotable and involving top managers in the process, the more effective they will be.
7. Principle of continuing development--The more an enterprise is committed to managerial competence, the more it requires managers who practice continuing self-development.

It is incumbent upon management to make personnel practices "fair" and equitable. A representative labor resource pool can facilitate this.

In summary, the following are paramount in staff development and promotion: (a) allocation of opportunity, (b) formal, periodic performance appraisals, (c) career development seminars, (d) self-development and skill enrichment programs.

Questions for Discussion

1. What are detrimental effects of a wide span of management? For e.g., decreased accountability, lack of uniformity in forming policy?
2. Can supervision be effective when an executive is responsible for nine subordinates? What is an acceptable number without decreased communication and compartmentalization occurring?
3. Name mechanisms for selecting both large and small numbers of employees. What are advantages and disadvantages of each?
4. What are some verifiable objectives against which personnel could be appraised?
5. Are affirmative action programs "reverse discrimination?" What are the implications for non-minority employees?
6. How and to what degree have criteria been identified to successfully predict managerial potential vs. performance?

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COMMENTARY FROM THE WHARTON SCHOOL

by Dr. Edward B. Shils and Dr. William Zucker

Basic to the future of the organization is the concept of the organization itself as Mr. Burns, the bureau chief, perceives it.

On the one hand, he desires an organization which is innovative and has operated in a rather laissez-faire manner, allowing his professionals to operate almost independently within the established guidelines and principles of the organization, yet on the other hand he is now agonizing over whether or not he should play the role of the bureaucrat which in many ways is inappropriate and ill becomes him as an innovative administrator and belies his seventeen years of service.

One of the ways in which he has maintained the high level of morale is that he has given to the professionals a high degree of responsibility. Organization lines are not particularly observed and, therefore, unless he is desirous of institutionalizing the organization and formalizing it in a manner in the past, then he should take either Mr. Harvey or Mrs. Ramsey, the former because of longevity in the organization, the latter because she is both a woman and a Black.

Some organizations, because of the nature of the executive who is in charge and the kind of professional supervision and participation of the professionals who report to the executive, do not have to have a formal organization, but can operate on a more participatory management level. This is understandably a tricky way in which to operate an organization. It takes a great deal of trust, understanding, and training, but it also requires a high degree of motivation on the part of all those who are involved in the organization and a level of dedication as well as a thorough grounding in the goals and objectives of the operation.

Thus, Mr. Burns is truly interested in maintaining the innovation and thrust of the organization. He would indicate that by the appointment of Mr. Johnson,

irrespective of the fact that he has only had two years of experience in the state and in the division and is the youngest of the three contenders. If justification is needed, Mr. Burns could fall back on the fact that Mr. Johnson is rated number three and the highest of the three contenders. On the other hand, if the organization is truly one which is dedicated to the concept of participatory management, then the appointment of Johnson would not be such a disastrous blow to the morale of the organization, although it might, indeed, have Mr. Harvey's nose out of joint which can be put back into place by giving him a special assignment in order to compensate for the loss of the position. The special assignment, although not giving him the title or the salary, would give him the added responsibility and might under those circumstances provide him with experience to break out of his bureaucratic mold and be part of the high level of professional competence.

If Mrs. Ramsey were to continue at her present pace then there would be no question that she would be considered for some future position at that level. Her pace of achievement has been rapid and undoubtedly will continue.

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INTRODUCING A CASE MANAGEMENT SYSTEM INTO A
CHILD WELFARE AGENCY THROUGH ORGANIZATIONAL DEVELOPMENT

by James Hackshaw, Ph.D. and Lonnie Stafford, M.S.W.

In 1973, the Board of Directors of the Gotham Home for Children became increasingly concerned with the pressures on child care agencies for program accountability. It believed that such accountability should demonstrate that program goals have kept pace with changing needs and changing service populations, and that it should also include measures of effectiveness.

A consultant was hired to conduct, in close collaboration with staff, an organizational assessment and to develop evaluation procedures. It was felt that problems of accountability could be solved more effectively with strong staff involvement.

As an outgrowth, the agency installed a case management system. Its ingredients are a management information system and a behavioral assessment instrument that monitors treatment needs and the growth of children in the residential treatment center.

The agency is now developing differential programming strategies to provide growth-producing experiences for the children. A research center has been created and the agency has become a teaching center for undergraduate and graduate students in child development, education and social welfare.

The Gotham Home for Children is a voluntary, non-profit, non-sectarian child care institution in Westchester County, a New York city suburb. The service population of 225 children, between six and eighteen, comes from New York city and its environs. It is approximately 85 per cent Black, 13 per cent Puerto Rican and 2 per cent White. All children are referred by the New York City Department of Social Services, courts and other community agencies.

A staff of 191 is located in the Child Care Department, Social Services Department, the School and the various support systems, i.e., Infirmary, Business Office, Chaplaincy, Transportation, Maintenance, Food Service, Clothing Division, Development Office. The Executive Staff directs the program.

The Child Care Department is responsible for the physical and emotional needs of the youngsters. There are eleven children's cottages, each with a team of child care workers which provides 24-hour care and supervision. The staff includes 65 child care workers, three senior child care workers, four supervisors, an assistant director, a director, a recreation supervisor, three full-time and six part-time recreation workers.

The Social Services Department offers case work services and psychiatric and psychological consultation to the children and their families. The department concentrates on alleviating the child's and the family's presenting and real problems to accomplish the speedy return of the child to his family. Alternative placement plans are used when return to the family is not in the child's interest. The Social Service Department Staff includes twelve social workers, three casework supervisors, two part-time psychiatrists, a psychologist, an assistant director, and a director.

Education is carried out through the Gotham Union Free School District #10, a New York State public school, located on the campus. All teachers are certified with experience in special education. The district principal is appointed by the Gotham Board of Education. The school program is diversified with class size restricted to ten students. One hundred thirty youngsters attend, all with special learning problems that require individualized instruction. Students who succeed here are sent to schools in the surrounding community.

Children discharged from Gotham are followed up by the agency's After-Care Office in New York city. This department locates foster homes, operates a group home program and provides support services for children and their families.

Forces for Change

Several factors prompted organizational evaluation. First, there was a decided shift in the ethnic composition of children served. Ten years ago they were primarily White. Today, they are predominantly Black and Puerto Rican. This called for attention to new role models that would have impact on this new constituency. New kinds of programming interventions had to be developed. In addition, there was the issue of greater representation from this target population at the board and senior management levels.

Second, increasing numbers of the children were being referred from psychiatric facilities and they needed a wider array of treatment interventions.

A third factor was the financial turmoil in most large metropolitan areas which generated pressures on agency boards and staff for more precise accountability and evaluative mechanisms.

Developing a Climate for Change

Negotiations between the board and the consultant were carried on by the agency's executive director. He outlined the tasks, a suggested time frame and the consulting fee. These were carefully developed with full participation of the board and the agency's resident director. Responsibility for the implementation of the organizational and service assessment was given to the resident director, Lonnie Stafford.

From the outset the resident director and the consultant agreed on an organization development approach which would foster a hospitable and supportive climate. Such an approach would focus more on group than individual management

development. The resident director's concern was to emphasize "process" and "task" foci equally. This process would stress the creation of effective agency groups and intergroups to:

1. Gather information on agency services and programs from the internal and external environment.
2. Organize, analyze, and feed such information to appropriate groups in the organization.
3. Develop and specify agency objectives.
4. Engage in joint action planning based on the analysis and discussion of the data.
5. Gain understanding, acceptance, and implementation of these plans throughout the organization.
6. Increase the capability of all units in the organization for solving internal problems of service delivery.

To provide a framework for the process, the agency was conceptualized as an open system composed of distinct subsystems. We defined a system as "a complex of elements in mutual interaction," and agreed that such an open system is related to and enters into exchanges with its environment. This view was of particular significance in that multiple disciplines in residential treatment agencies function side by side and tend to view their responsibility as related to their own department. Thus, they often see staff as department employees rather than as organization employees. Change would then involve a move from a departmentalized organization which operates programs to a basically inter-departmental organization in terms of activities to be performed.

The Organizational Entree of the Consultant

A memorandum to staff explained the board's decision to hire a consultant. In addition, there was a meeting of department heads to outline the board's interest in an agency assessment and evaluation, and to define the role of the consultant. Since the consultant was employed for only one day a week, there

was an initial observation period for the first several weeks to gain some feel for the agency. During this period, the consultant stayed on the sidelines and watched the staff and children in their daily activities. This approach did not prove particularly helpful since there was no criteria against which to observe the activity and determine whether it was characteristic of a particular individual (staff or child) or a goal directed treatment situation.

A much more fruitful method of gaining entree was through unstructured interviews. These were carried out with the executive director, the resident director (who is responsible for the direction of program services to the children in residence) the department directors in social service, child care, and the infirmary. Since the agency also operated a regular school program on the campus as well as a cooperative educational program with several of the community public schools, interviews were held with the District Superintendent and the elementary and middle school principals. The interviews provided several benefits. First, they established a relationship with each person who would eventually be involved in the organization development process. Second, the interviewees were excellent informants on key persons in their departments who were knowledgeable about practice issues, and who were also opinion molders in the agency through the informal system. Interviewing these key informants eventually proved crucially important in garnering agency-wide acceptance for the organization development process. A third benefit was the data provided to the consultant on significant service delivery issues as seen from the executive, middle management, and line workers viewpoints. Useful, too, were the pinpointing of leverage points within the organization for initiating change and receiving first-hand suggestions for organizational improvement. A final benefit was the insight gained from the interviews on organizational processes, including actors and groups in the decision-making process, communication channeling--formal and informal, and intragroup and intergroup relations.

The consultant also attended unit, departmental and interdepartmental meetings which supplemented the interview information on decision-making and agency communication processes.

Developing a Structure for the Change Effort

By mid-November, the organizational assessment was complete and change efforts were to begin in early January. This respite avoided interference with holiday programming, and permitted the executive director, the resident director, and the consultant to form strategy for initiating change.

The approach agreed upon was that of an agency-wide Task Force to represent a diagonal slice of the organization from top management through relevant functional or program areas. Consideration was given to tapping the interests, knowledge and skills of agency members who had been identified as opinion molders in the informal network. It was recognized that group heterogeneity was considerably heightened by this approach, yet we believed that the problem solving potential would be expanded since more alternatives would be generated. In addition, we felt that a major implementation link would be forged by tapping both the formal and informal communication networks of the agency.

The executive director, the resident director and the consultant each prepared lists of staff persons they believed should be on the Task Force. The final selection was made after lists were compared and discussed. The board's executive committee was then asked to appoint an official representative to the Task Force. By mid-December, all potential participants were identified, including departmental directors and representatives from all of the subsystems -- social service, child care, school, infirmary, maintenance, business office, and clerical staff. In some cases there was more than one participant from a unit (subsystem).

Organizational Implementation Phase I

Early in January, each potential participant received a letter asking whether he/she wished to serve on the board authorized Task Force Committee. It stressed that the assessment and evaluation were of major importance to the board and that the outcomes of the Task Force deliberations would have important effects on the organization. Consultations were also held with each of the departmental directors to inform them of the process. Needless to say, all those who were asked to serve agreed.

In planning the first meeting, the resident director felt that the process would be safeguarded by having the consultant serve as chairman of the Task Force. This would establish this was not just another agency group convened by the resident director with "business as usual" as the pitch.

The first meeting was held in mid-January with all present. The consultant outlined his role and function as:

1. Helping to design and implement methods of obtaining information on the organization and its external environment. (The external environment was of major importance since the agency was located in a high-income, suburban community and most of the clientele came from low-income, inner-city communities.)
2. Helping to designate sub-committees to identify issues, suggest program alterations and prepare reports for Task Force action.
3. Helping to maintain interaction among committee members and to retain focus on the problems to be resolved.
4. Helping to monitor the overall committee progress in the context of the time frame suggested by the board.

Discussion focused the Task Force as a mechanism for influencing policy decisions on service delivery. However, for committee effectiveness, participants had to engage in frank and open discussions without fear of retaliation. An important issue was that there was no guarantee that all of the Task Force recommendations would be accepted by the board. However, representation from

the board and from the executive director assured that recommendations for action were realistic.

Since all participants knew one another, it was easy to establish subcommittees, and this was achieved by the end of the third session.

Subcommittees were:

1. Goals and Objectives
2. Staff Training and Development
3. Development of Gotham as a Learning Center in Human Resources

Task Force meetings were held every two weeks, careful minutes were kept and circulated with the agendas in advance of each meeting. Subcommittees began meeting regularly and submitted periodic reports to the Task Force on achievements and barriers to achievement. The Task Force encouraged communication and coordination across departmental lines.

It was agreed that each subcommittee chairman would present his/her final recommendations in person to the board and negotiate directly with the board any changes or amendments.

A summary of the actions and follow up on each subcommittee follows. All of the recommendations were approved by the board at the June meeting.

Task Force on Staff Training and Development - Agency Psychologist, Chairman

Three major recommendations were made:

1. The development of a series of video tapes to be used as training modules.
2. An affiliation with the Empire State College which certifies the home as a University Training Center for the college. Employees and others would be able to take college level courses on the Gotham Campus and would receive credits towards Associate and Bachelor Degrees. This recommendation was made operational in September.

3. A planned program of orientation for all new staff members. This recommendation has also been made operational to a limited degree.

Task Force to Develop Gotham as a Learning Center - Director of Social Service,
Director of Child Care, Co-Chairmen

1. It was recommended that affiliations be developed with a number of colleges and universities to use internships, field placements and on-the-job training.
 - a) During the summer, a contract was worked out with the Urban League to use Gotham as a center for on-the-job training.
 - b) Beginning in September, college students were placed for internships in education, child care and recreation.
 - c) First and second year students from three graduate schools of social work have been placed on the main campus and in the City Office for field placements.

Task Force on Goals and Objectives - Learning Specialist - School District,
Chairperson

There were four categories of goals and objectives:

1. Goals specifically directed to the well being of Gotham children.
2. Goals which focus on the development and application of knowledge about child welfare practices.
3. Goals which are directed toward strengthening the organization.
4. Goals directed to community services in the interests of children.

Child Welfare Goals

1. To identify each child's and his/her family's needs and strengths based on an assessment by each discipline.
2. To prepare each child to return to his/her family or to an alternate placement in a time commensurate with his learning and developmental stage, and the development and growth of the family to accommodate the child.

3. To establish a systematic treatment and discharge plan for each child which includes periodic reviews of progress and the appropriateness of the current discharge plan.
4. To provide a positive growth and learning environment for children who will need continuous long-term care at Gotham because of the lack of community resources.

Knowledge and Skill Goals

1. To develop Gotham as a facility for the training of personnel in the human services.
2. To stimulate the study and application of new developments in child welfare theories and practices to benefit the children.
3. To systematically collect, maintain and evaluate information on the composition, service categories and trends of the Gotham population as a basis for program and planning efforts.

Organization Development Goals

1. To develop an organizational environment that will foster positive relationships, growth and learning opportunities for the children, their families and staff.
2. To develop and apply systematic methods of internal communication to enhance the understanding of all units about Gotham's mission.
3. To decrease the impact of institutionalization on the children by developing and utilizing links between the agency and the community.
4. To make maximum use of all facilities at Gotham for the development and enhancement of the Gotham population.
5. To reassess the goals and objectives of Gotham annually.
6. To have each department define its objectives by October.

Community Service Goals

1. To adjust to new developments and trends in child welfare by developing and maintaining close working relationships with health, welfare and education agencies.

2. To develop, strengthen and enhance the self-identity of Gotham children through maximum use of the social, economic and program services of Black and Hispanic communities.

Organizational Implementation Phase II

The successful completion of Phase I triggered agency interest in the development of a case management system. The Goals and Objectives Committee was reconvened, and, with the consultant, began the process of developing an evaluation instrument to measure the degree of social growth by children while at Gotham.

DOCUMENT A

FLOW CHART OF THE GOALS AND OBJECTIVES COMMITTEE
FOR DEVELOPING BEHAVIORAL OBJECTIVES

STAGE	COMMITTEE TASK
Specifications of Behaviors of interest	1. Agreeing on model for child behavior, e.g., Erik Erikson's five stages for child development
What behaviors should the child exhibit as seen by: child care social service school	- sense of trust - sense of autonomy - sense of initiative - sense of industry - sense of identity
Agreement on behaviors	Securing agreement by: child care school representatives social services
Extraction of common attributes of behaviors	That these behaviors are those which their departments wish to be developed. What do these behaviors look like, e.g., trust - how do we know when trust is being exhibited?
Determination as to whether behaviors specified have the listed attributes.	

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DOCUMENT A (continued)

FLOW CHART OF THE GOALS AND OBJECTIVES COMMITTEE
FOR DEVELOPING BEHAVIORAL OBJECTIVES

STAGE	COMMITTEE TASK
Formulation of working definitions of the behaviors selected.	Test definitions among committee members
Definitions to be examined by staff members in: child care school social service	Committee members to present working definitions with some examples of behavior that conform to the definition.
Presentations of definitions and examples to total staff.	Working definitions presented to staff with examples of behaviors that conform and some examples that do not conform. Staff members will be asked to choose examples of behavior they believe fit the definition.
Examples of behaviors collected from staff members in each department.	
Staff sessions on choosing example to match behavior.	Resources are analyzed by how many examples (true) are left out and how many false examples are picked. When zero is the answer for both questions, definition is ready for the next step.

DOCUMENT A (continued)

FLOW CHART OF THE GOALS AND OBJECTIVES COMMITTEE
FOR DEVELOPING BEHAVIORAL OBJECTIVES

STAGE	COMMITTEE TASK
Record definition.	
List agency behaviors fitting the definition.	
Write the objectives based on the list.	
Incorporate into the instrument.	
Scale instrument.	
Introduce instrument to the agency.	

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MENTAL HEALTH ADMINISTRATIVE LEADERSHIP PROBLEM

by Harold L. McPheeters, M.D.

This case is presented by the Commissioner of the Department of Mental Health of a border state. The Commissioner assumed his role after the first five years of the department's existence, and focuses on the problems facing a new leader in a relatively new program.

Until the passage of the legislation that created the independent Department of Mental Health, the four state hospitals had operated in a Department of Welfare that included prisons, tuberculosis hospitals, mental hospitals, the state's one institution for the retarded, childrens' institutions, the public assistance program and the probation and parole program. There had been a small Mental Health Division consisting of three persons in the State Health Department.

The new Department of Mental Health was given responsibility for the operation of the four state hospitals and the Community Services Division (as the unit from the Health Department was renamed). The early years of the Department of Mental Health were busy ones concerned with developing basic procedures for the department, and especially with finding a cadre of trained mental health professionals. This was a period during which state government was also becoming professionalized with budget analyses and line item budgets instead of the former lump sum budgets, and a move to a competent personnel system rather than the former patronage plan. All of the work to establish these new administrative procedures, a statistical reporting system, to make further changes in admissions laws, and to recruit and train some basically competent people had taken the full time efforts of the first commissioner of the department.

Now there was a basic corps of competent professionals, and stipend programs were preparing others. Psychiatric aide training had been undertaken for all aides--even those who had been employed for some years. Basic budgeting, administrative,

personnel and statistical services had been put into effect. While these services were rudimentary by some of today's standards, they were essentially adequate for that time and a tremendous accomplishment for the program.

The four state hospitals ranged in size from 1,600 to 2,400 patients with a total of 7,500 patients in residence. All hospitals served a geographic section of the state for all admissions from that sector, except that dangerous patients were sent to an over-crowded maximum security unit at one of the hospitals. There was no separate program for children or adolescents. Separate Black ward buildings maintained segregation at the hospitals.

Now it was possible to look at the program itself to see just where it had headed. Suddenly the program directions were not so clear.

The statute establishing the new department simply charged it with "the care and treatment of the mentally ill." This was hardly sufficient to set a firm direction. At the time, psychiatric treatment was in considerable change as a result of the recent introduction of tranquilizers. A major commitment had already been made through the Governor's emergency fund to begin the use of these medications on a wide scale in the hospitals. They had transformed the basic climate of the wards from that of milling tension, interrupted by occasional outbursts of fights or screams, to a kind of uneasy apathy.

It had been assumed that having competent mental health professionals in the program would automatically give direction to the program; that the professionals by virtue of their training would know exactly how to proceed with programs. But it became increasingly clear that this was not the case. Instead, each professional person came with his own set of beliefs, values, biases, etc., about how mental hospital programs should be run. Sometimes these were beliefs based on professional prerogatives, sometimes on personal experiences, and sometimes on personality factors.

At the Central Office of the Department, the divergent thinking of various key

individuals throughout the hospitals manifested itself in such ways as :

--A request was received from one hospital to expand its hydrotherapy department while others were wanting to discontinue hydrotherapy and convert the facilities to other uses.

--One hospital wanted to integrate its infirmary units while another requested a new Black ward building--citing especially the need for better infirmary facilities for those patients.

--One hospital requested improved farm facilities, especially a poultry program, citing therapeutic benefits to patients (i.e., fresh eggs and working opportunities) while others wanted to sell their farms because they had no therapeutic value.

--One hospital was opening wards and granting grounds and town privileges to patients while another was requesting additional staff for security and "coverage" to prevent run-aways from their already totally locked and tightly regimented hospital.

--One hospital reported an average of 16,000-17,000 total hours of seclusion and restraint per month while another, with more patients in residence, was reporting an average between 1,000 and 1,500 total hours.

--One hospital discontinued ordering any chlorpromazine tablets of less than 100 mgm size while another hospital ordered nothing but smaller sized tablets. Still another hospital used very little of either but reported large numbers of patients receiving electro convulsive treatment.

--Three hospitals discontinued insulin therapy entirely while a fourth requested more personnel to increase its use of sub-coma insulin therapy. (Patients were not transferred between hospitals for this treatment).

--One hospital requested permission to set up an Alcoholic Rehabilitation Unit while another wished to confront the judges of its region for "illegal" commitment of alcoholics who were not actually "mentally ill".

--One hospital's social service department had reduced the hospital's census by about 100 patients by a diligent home going program for long-term patients. Subsequently, one of the other hospitals which had no such program requested permission to transfer 100 of its long-term patients to that hospital to relieve "our overcrowding."

--One hospital requested permission to mail out medications at cost, or free if the family was indigent, to former patients on leave status. Another hospital refused to send out any medications and insisted that patients seek out their own private physicians for any further prescriptions after they had left the hospital.

--One hospital requested that funds be sought for a separate children's unit while another suggested this would be a waste of money since children were best treated in adult wards where they could interact with adults just as they do in a family.

There were administrative problems, of course, in justifying such divergent requests to the State Budget Division and the Legislature. But of far more concern to the writer was the confusion that it represented, in terms of philosophies, objectives, programs and methods. Within a Department of Mental Health there surely should be room for differing philosophies and approaches that reflect the different professional and personal biases of individual workers. Yet, it was apparent that most of these differences were based on professional or social biases that overlooked patient needs. How could this whole issue of policy direction be refocused on meeting patient needs in a department of 2,000 employees in four different hospitals?

The writer had attended a program in Executive Development for psychiatric administrators at the University of Chicago and had been impressed by the teachings of Chester Barnard, Philip Selznick and others, that it is the role of leadership in an organization to set the philosophy and goals of the organization and to see to it that they were promulgated to the staff members throughout the organization. This was a worthy aspiration--and it clearly needed to be done. But how?--especially when one is dealing with dedicated and well-qualified persons. In some cases the very fact that people were so well qualified was part of the problem, for it gave

them a greater feeling of allegiance to their profession and its values than to the program or the patients.

The Department had an Advisory Board of 12 persons--half psychiatrists from the community and half lay persons--which met quarterly. At that time the department also had full-time or part-time specialty consultants in psychiatric social work, psychiatric nursing, clinical psychology, occupational therapy, and the chaplaincy.

How was the commissioner to approach this matter of setting philosophies and goals for the hospitals so that programs and methods would be more sensitive to patient and family needs? Who should be involved? What would be the role of the Commissioner himself, his board, his consultants? What would be the mechanism for doing this? How would the results be promulgated and operationalized? How would it affect the long-range future as well as the immediate future? This was the administrative leadership problem that faced the writer.

IMPLEMENTING INNOVATIVE CLINICAL RECORDS SYSTEMS IN A COMPREHENSIVE
COMMUNITY MENTAL HEALTH CENTER: FIVE CASE STUDIES

by: Whiton Stewart Paine, Ph.D. and Carol Gillis, B.A.

This case study reports on how a comprehensive community mental health center is responding to the need for quality clinical records in its mental health services. It presents five case histories, all tied to the implementation of different systems for clinical records on mental health services. After a brief discussion of the overall community mental health center and of the mandate for these systems, the five projects are presented, giving background, present status and future considerations.

These clinical records systems resulted from similar sequences of administrative activities. First, an administrator establishes the mandate, the policy which codifies the need for change. Second, the Research & Evaluation Service (part of the central CMHC administration) works with unit and subunit directors to develop preliminary forms and procedures. R&E personnel serve as both technical consultants and persistent motivators. The unit administrators then work with the clinical staff to further develop, implement and modify each system. Eventually, this leads to a formal evaluation under the direction of R&E.

Each one represents a somewhat different set of administrative tasks and problems related to innovations in diverse clinical services. These projects involve: 1) developing a center-wide set of related clinical forms, 2) implementing Goal Attainment Scaling in a partial hospitalization program, 3) developing a hybrid Client Oriented System in an outpatient base service unit, and 4) and 5) establishing a modified problem oriented record format on an inpatient service and on a crisis service.

These case studies indicate that much innovation is interpersonal and serendipitous, is based on consistent communications and on determining when to feed into an ongoing clinical system precise information which will lead to change. In these cases, the central community mental health center administration has not forced change. It has facilitated innovations to be developed by unit administrators and clinicians.

Background

The Crozer-Chester Community Mental Health Center is a new organization which began as a comprehensive facility in the Spring of 1974. Like many community mental health centers, it is a peculiar hybrid, an amalgam of new and established services. There are three programs at a number of different locations, as follows:

TYPE	ALCOHOLISM PROGRAM	DRUG PROGRAM	MH/MR PROGRAM
Crisis Intervention	Alcohol Crisis Unit	Drug Crisis Unit	MH/MR Crisis Unit
Inpatient	Medical Detox	Medical Detox	Inpatient Psychiatric Service
Residential	Residential Service	Drug Residential Service	None
	Non-Medical Detox Service		
Partial Hospitalization	Intermediate Service	None	Partial Hospitalization Service
			Preschool Therapeutic Service
Outpatient	Alcohol Outpatient Service	Drug Outpatient Service	Adult Acute Care Unit
			Childrens Acute Care Unit
		Methadone Service	Aftercare Unit
			Mental Retardation Service

Within the CMHC, the Crisis Units form a Crisis Service, the MH/MR Outpatient Units form a state supported Base Service Unit.

The CMHC is part of a larger medical center, and serves a heterogenous catchment area of 114,000. Included is a deteriorating industrial city (Chester, Pennsylvania) surrounded by blue and white collar suburbs. Within the city, the population is almost 50 per cent Black; the suburbs are 95 per cent White. Next year (1976) the CMHC will deliver approximately 100,000 units of service. Service units include inpatient and residential days; three-hour, partial hospitalization units and outpatient contacts.

A Central Administrative Service includes consultation and education, volunteer program, research and evaluation and vocational counseling services. The Comprehensive Alcoholism Program also has an Administrative Service. An M.S.W. social worker serves as CMHC Director, and the Medical Director is a psychiatrist. Most of the CMHC staff are credentialed psychiatrists, psychologists, social workers, psychiatric nurses with some paraprofessionals on the drug and alcohol units. The CMHC is committed to innovation and to high quality service, which has already led to a strong training program associated with five local colleges and universities, and a variety of research projects. A separate aspect of this commitment was the mandate for innovations in clinical records.

This mandate was defined by the CMHC Director when he asked the Research and Evaluation Director to work with the clinical services to develop record-keeping procedures that would:

1. Facilitate the quality of care given clients.
2. Support continuity of care procedures.
3. Satisfy accountability and external standards requirements.
4. Aid in efficient case management.
5. Facilitate staff development.
6. Be congruent with recent trends in the organization of clinical records.

After reviewing literature, this mandate was expanded into a set of general CMHC wide goals that called for each unit to develop an integrated records-keeping system that:

1. Systematically documents the amount and type of care delivered to each client.
2. Documents the clinical decisions made during the delivery of service.
3. Concentrates staff attention on a limited set of problems and/or goals for each case.
4. Reports the overall outcome of treatment.
5. Minimizes unnecessary writing, yet assures that certain data is routinely collected on all clients.
6. Satisfies the external requirements of federal, state and county funding sources.
7. Satisfies the standards set forth by the Joint Commission on Accreditation of Hospitals.
8. Is congruent with the needs and goals of each Service.
9. Facilitates communication between disciplines and Services.
10. Reflects recent trends in the clinical records area.
11. Supports the conduct of research and evaluation studies.
12. Aids in the training of new staff.
13. Is closely related to the fiscal and accounting systems.
14. Contributes to the general quality of client care.

The Mental Health Program's needs for clinical records systems plus the goals stated above led to five different projects.

First, a center-wide set of general clinical forms to document intakes and discharges had to be designed and implemented. Separate internal systems for the Psychiatric Inpatient Service, the Crisis Service, the Partial Hospitalization Program and the Outpatient Service had to be developed. Each task involved three

linked sets of administrative activities. First, overall and unit requirements were defined. Second, the literature was searched for appropriate tools and procedures and, wherever needed, outside experts were consulted. Third, an implementation strategy was developed by the Research & Evaluation Service.

The relevant CMHC goals define the overall requirements. An understanding of the background of each service unit -- of its goals, history and of the needs of its administrative staff, clinical personnel and clients -- plus the study of work done elsewhere, provided basis for negotiation between the Unit or Service Director and the Research and Evaluation Director about the type of records system to be implemented. A degree of agreement is a crucial first step in developing implementation strategy.

Implementation involves standards setting, technical support, continuing negotiation and feedback. Basically, R&E personnel serve as "expert consultants" who provide reprints and other technical support as they work directly with administrative and clinical personnel on designing and testing different procedures. Input from the clinical staff is continuously solicited and, whenever possible, staff is closely involved in each step. Finally, the R&E Service formally evaluates each system.

At present (January, 1976), the status of the five tasks is that the overall CMHC forms have been implemented, Goal Attainment Scaling has been operating on the Partial Hospitalization Service for one year, the Base Service Unit is well into the development of a hybrid, client-oriented systems and the Crisis Service and the Psychiatric Inpatient Service have agreed to develop a system based on the Problem Oriented Record. Each task is discussed in more detail below.

Task I: Center-Wide Records Forms

The use of different forms for documenting the intake and discharge of clients had become increasingly unsatisfactory and also conflicted with goals

2, 5, 6, 7, 9, 10, 11, and 13. Funding and standards agencies were negative about clinical records on a number of Services; there were communication difficulties when clients were transferred within the CMHC, and it was difficult to obtain the center-wide data needed for federal and other reports. The need for standardized forms was clear, but the problems were initially underestimated. Differing unit requirements and changing state and county forms complicated the development of standardized instruments.

First, records from nearby CMHC's published forms and state, county and federal forms were reviewed. Preliminary instruments were designed and discussed with a committee of unit administrators and staff. Then the forms were pilot tested on selected units, and staff was interviewed about possible changes. Meanwhile, the county mandated intake sheet was modified and the Governor's Council on Drugs and Alcohol implemented the Uniform Data Collection System. This system suddenly required drug and alcohol clinicians to collect large amounts of data at intake. Attempts to incorporate county and UDCS items in the CMHC forms were ineffective and these external requirements severely restricted the information that could be included on the separate center-wide forms.

The entire design and implementation process took more than a year. In its last stages, this work involved a series of meetings with the administrators of the Comprehensive Alcoholism Program, Crisis Service and the Base Service Unit to obtain consensus on forms which pleased most, offended few, and met with appropriate goals. Input from these administrators was important because their services had the most intakes and discharges.

Five instruments were in the final set. The Intake Face Sheet collects basic demographic information and documents the actions of the unit. It is

supplemented by the narrative Intake Summary. Liability Worksheets were developed for the slightly differing procedures mandated for Drug and MH/MR liability determinations. A flexible Change of Status form documents discharges, transfers within the CMHC, and referrals outside the CMHC. It is supplemented by a narrative Treatment Summary. The Intake Face Sheet and Change of Status sheet are in the Appendix.

These forms replace a wide variety of documents (telephone contact sheets, discharge summaries, worksheets, etc.). Additionally, the Change of Status Form aided central administration in establishing continuity of care mechanisms.

Final implementation included the development of comprehensive written directions and definitions for each form. These were bound into a handbook and distributed to all clinical and administrative staff. R&E personnel held training sessions in each unit, resulting in minimal disruption of ongoing clinical activities. Clinical staff freely critiqued the earlier forms, and the absence of negative comments suggests that the new forms are being used without major problems.

Starting in February, 1976, a copy of all Intake Face Sheets and Change of Status forms will be sent routinely to the R&E Service for evaluation and determination of the further training required in the differing units. Within the next two years it is expected that these forms will have to be redesigned as part of the development of a computerized data base management information system. The experience gained in Task I should aid in accomplishing this task.

Task II: Goal Attainment Scaling on Partial Hospitalization

The adult Partial Hospitalization Program, a new service, has a capacity of 24 clients at each three-hour daily session and is staffed by Charlotte Yoder,

an M.S.W. Unit Director, an art therapist, two bachelor's level social workers and a secretary. Many of its clients are from the state hospital or the Inpatient Service. Psychologically, the staff is close knit and this is an unusually cohesive service. As individuals, they are enthusiastic, hard working and innovative. The unit's clinical files were traditional in format, well organized and comprehensive. However, there was a recognized need for record-keeping procedures which would help structure both the development of treatment plans and therapeutic interactions with clients.

The Service Director had been aware of this need even before the unit was established. She had approached R&E for assistance in implementing Goal Attainment Scaling, a well-developed, comprehensive system in which therapist and client define a set of goals. A five point scale is constructed for each goal by defining the expected outcomes and actual outcomes of treatment.

The goal chart (list) is used to structure the treatment plan and is referred to, and, if necessary, modified, when later clinical decisions are made. Naturally, the full system is more elaborate than can be discussed here. The basic design was presented in 1968 by Kiresuk and Sherman. More recent information is available in Evaluation Magazines Special Monograph #1, entitled, Four Ways to Goal Attainment (1973) and two recent articles (Kiresuk and Lund, 1975; Bolin and Kivens, 1975). The goal sheet can be used to generate a unitary number which documents changes between intake and discharge.

The basic GAS forms are duplicated in the appendix. They include a cover sheet which documents which staff worked on this case and indicates how and when the follow-up is to be done. The Level of Functioning at Intake indicates the goal areas and the client's initial functioning. Finally, the Goal Attainment

Follow-Up Guide details the predicted levels for each goal, and is used by R&E personnel to interview clients after discharge.

The introduction of GAS began with two one-and-one-half-hour sessions with the Unit Director. Before the system was initiated, the Unit Director and evaluator attended a conference. There were also three one-and-one-half-hour group introduction and training sessions to explain the techniques (via role playing), and there was extensive discussion. The staff then reviewed five cases of individuals already involved in the program, and the evaluator and therapist reviewed the GAS established for them. The time involved in this aspect was about one hour for staff and six hours for the evaluator. A pilot implementation was done from January, 1975 to April, 1975, followed by another staff session to review problems and obtain feedback about effectiveness. The staff liked GAS, stating, "it helps the therapist by supplying structure", "it helps the intake interviewer connect with the core therapist and sets the tone for the treatment".

Starting in February, 1976, all cases in which GAS were used during 1975 are being reviewed and follow-ups done as part of an initial evaluation. The staff has suggested modifications to the basic GAS format including periodic case reviews, a seven point scale and extension of GAS to such areas as art therapy. These will be pilot tested and implemented.

A variant on GAS is now being used on the day service in the Alcoholism Program and GAS will be used in the diagnostic nursery unit which will open in the Spring of 1976. Thus, all partial hospitalization services of the CMHC will ultimately be using GAS.

Task III: A Hybrid System on the BSU

In 1967, the CMHC Mental Health Outpatient Service (Base Service Unit IV) began as a satellite child guidance clinic. Two years later, it was expanded

into a state supported Base Service Unit offering a range of services to children and adults. Then, despite some staff and administrative reluctance, the BSU was incorporated into the Medical Center and, when funds finally became available in 1974, was expanded further and became an important part of the new comprehensive Community Mental Health Center. At present, the Unit has five major components, with a total capacity of 1,100 sessions a month: a therapeutic preschool nursery, children's and adult acute care outpatient services and programs for the mentally retarded and for patients discharged from state hospitals. These major organizational changes were accomplished without major loss of staff, and Dr. Leighton Jones remained Director over this span of time.

The CMHC Director announced, in December, 1975, that there would be a further reorganization of the BSU into an Outpatient Service. The changes would include administrative modifications which would reflect the separate, but linked, adult crisis unit, children's crisis unit, community support unit, mental retardation service and preschool therapeutic partial hospitalization service. Each of these service units is staffed with a different mix of psychiatrists, psychologists, social workers and other professionals. Steven Simminger, Ph.D., became Administrative Director and Arthur Moffa, M.S.W., Director of the Adult Program.

As the BSU developed and changed, the clinical records area was given a higher administrative priority, reflecting strong internal and external pressures. Internally, as the clinic became more complex, there was increasing difficulty in maintaining and retrieving case records. At one stage there were five separate records systems, client files were being misplaced and duplicated, and staff was having difficulty using old files for readmitted clients. Externally, the county and its R&E Director, Donald Paretchan, had been working with Fredrick Newman and had accepted the approach to program accountability presented in

Carter and Newman's A Workbook and Guide. The BSU is program funded through the county MH/MR Program and is periodically evaluated by the county R&E Director. Past county evaluation had stressed problems in the Service clinical records.

A hybrid system, loosely based on Carter and Newman's (1975) Client Oriented System, is being implemented in this Psychiatric Outpatient Service. This project represents one solution to the common problem of implementing major modifications on an agency which has been incorporated into a somewhat alien structure, a comprehensive Community Mental Health Center.

Newman's approach involves a set of standards and suggested procedures which can be used by the developers of a clinical records system to generate a system which: 1) is client oriented, 2) facilitates continuity of care, 3) is directly tied to the cost/benefit analysis of delivery of services, and 4) is oriented toward the efficient management of service delivery. A detailed description of the approach is found in Carter, D. E. and Newman, J. L. A Client Oriented System of Mental Health Service Delivery and Program Management: A Workbook and Guide.

Important elements of the Newman approach include the use of levels-of-general-functioning scales, case review procedures, assignment of direct and indirect costs to individual cases, problem and goal definition as part of the treatment plan, and cost analysis procedures. These elements are compatible with either Goal Attainment Scaling or the Problem Oriented Record. A model implementation of Client Oriented System was recently reported on by Barbara Burwell (Burwell, Reiber, Calloway and Newman, 1975). All of the BSU's in Delaware County will eventually be using the Client Oriented System. Strategy selected is complex and lengthy. It involves six main stages:

- I. Development of levels-of-functioning scales.
- II. Merging of clinical records into a single set of files.
- III. Modification and acceptance of center-wide forms.
- IV. Design and implementation of an integrated treatment plan format.
- V. Design and implementation of a standardized clinical record format including a staff log.
- VI. Evaluation studies of the final system.

These stages are seen as taking a minimum of two years. As of January, 1976, the project is in stages IV and V. In all stages, the strategy has been to first involve the administrative committee of the clinic to obtain its input, then to consult with the staff and committee as procedures are implemented and modified.

Stage I: Development of Levels of Functioning Scales

Because of county pressure, developing a scale to assign clients' level of functioning became the first major clinical records activity. From an R&E standpoint, this task involved providing administrative and clinical staff with information on LOF scales developed elsewhere and then acting as a technical consultant as the unit developed its own scale. This is not equivalent to re-inventing the wheel. A staff-developed product is more likely to be used appropriately because it becomes the common property, and responsibility, of all.

In this process, the BSU rejected the idea of a single level of function scale and instead developed three scales relating to vocational/educational functioning, social functioning and a rating of self-worth/depression. A copy of this scale is in the appendix. A preliminary analysis of six weeks worth of data indicated adequate initial levels of reliability and validity. Development work on this scale continues.

Stage II: Merging of Clinical Files

This step was done by the unit itself with minimal external assistance. Clinical records, color coded and filed as either open or closed cases, have resulted in increased efficiency in the retrieval of files and increased staff satisfaction. Some minor problems remain, but this step appears to have been completed satisfactorily. Most of the "donkey work" was done by administrators working with clerical staff, rather than by clinical staff.

Stage III: Center-Wide Forms

The BSU participated actively in the development of center-wide forms, and some pilot testing was done on the service. Final implementation was done with little difficulty.

Stage IV: Integrated Treatment Plan

The task of developing an integrated treatment plan format grows logically from Stage III. The broad parameters for such a subsystem were established through negotiation with the county R&E Director and with Fredrick Newman, representing the State. Then, the outpatient Service's administrative committee and the CMHC R&E Director worked together in developing a possible format. This format involves major changes in the way cases are managed on the Unit. Its major features are:

1. Problem and Goal Definition Done at Intake

- a) At intake, a clinician fills in the Client Goals Sheet (see Appendix) which covers client problems, treatment goals, treatment modalities to be used and levels of functioning. On this sheet:
 - 1) Problems will be defined as specifically as possible.
 - 2) Goals will also be specific, and, if possible, behavioral. Short and long-term goals will be defined.

- 3) Treatment plan will be tied to goals and will include type, frequency and duration of treatment.
- 4) The problems will be linked to one or more of the areas of functioning.

2. Level of Functioning

- a) At intake, the therapist will assign the levels of functioning, and weigh each area in terms of importance.

3. Case Review (a significant departure from past practice)

- a) Clinician review. Each case will be reviewed periodically by the primary therapist.
- b) Supervisor review. Certain cases will be reviewed by a supervisor. These include:
 - 1) Those requiring more than a preset number of sessions.
 - 2) Those reflecting a significant negative change in the client's level of functioning.
 - 3) Any case that the primary therapist feels should be reviewed by his supervisor.
 - 4) A randomly selected sample of cases.

The review of cases by supervisors is intended to aid clinicians in working with more difficult cases.

Unit clinical staff is being trained on this set of procedures, and it is expected that it will extensively modify the above steps. The inclusion of both problems and goals reflects philosophical differences between different disciplines. During the next six months, staff is expected to become proficient in defining problems and establishing behaviorally oriented goals. This process has already begun. As implementation proceeds, the R&E Director will begin reliability and validity studies and this should lead to further modifications. This process should be completed by the Summer of 1976. It is hoped that the final system will include elements of POR and GAS. Recently, Garwick (1975) has addressed some of the problems of combining elements of these approaches.

Stage V: Standardized Clinical Record

Presently, the contents of a case record are simply kept together in a standard manila folder, and this is not congruent with the best use of the standardized forms and the Client Goals Sheet. Therefore, the Unit has decided to go to a standard binder which, through the use of internal dividers with attached clips, will facilitate the easy review of the intake sheet, financial form, Client Goals Sheet and notes.

Related to the clinical record is a new Staff Log on which the clinical staff records all direct and indirect (case management) services related to specific cases. This information is used to document the delivery of services and also leads to the evaluation of how staff time is spent.

Stage VI: Evaluation Studies

Once the entire system has been developed, it will be evaluated on its own merits and compared with the POR and GAS systems implemented on other mental health units of the CMHC.

As this case study illustrates, changing record-keeping procedures affects other aspects of the case management system. Additionally, external agencies, in this case, the county, can be potent motivators of internal change. Finally, the major work on this service remains to be done. Obtaining staff agreement on how goals and problems are defined will require a great deal of time and discussion, but these activities should aid the service as it is reorganized.

Starting in February, 1976, a similar system for clinical records will be developed in the Outpatient Alcoholism Service. Later, the Drug Outpatient Service may also be included.

Task IV: Problem Oriented Record on Inpatient

The situation on the Inpatient Psychiatric Service is in some ways similar to the Base Service Unit. Both units are large, staffed by professionals from a variety of disciplines and undergoing internal changes. Two major differences between these services are that the changes on Inpatient were more turbulent, and that the administrative personnel on this service are more sophisticated about clinical records systems and more interested in innovation. Unlike the BSU, here there is more internal motivation for change and less external motivation. The latter situation has changed somewhat since the Unit underwent JCAH evaluation in January, 1976, and reflects that JCAH requirements are congruent with the approach to clinical records embodied in the Problem Oriented Record.

In late June, 1974, the Inpatient Psychiatric Service accepted its first patients. Within three months, it was filled to capacity (28 beds), and since that time, it has run at more than 90 per cent of capacity. Implementing such a psychiatric service presents a variety of challenges to a medical institution not accustomed to this type of facility. One initial organizational task involved clarifying the new service's administrative functions as they relate to the policies and procedures of the pre-existing Department of Nursing. Models of nursing administration, previously based on the structure of medical/surgical wards, had to be modified to accommodate the requirements of a psychiatric ward. It was difficult and time consuming. The final resolution led to a modified administrative structure and a somewhat different staffing pattern on the Service.

The Unit Director, Roy Fitzgerald, M.D., had been verbally committed to the development of a POR-type records system for more than a year. Records keeping had not been a major priority when the unit was established and the

present clinical files, while adequate, were not contributing maximally to the management of patients. Because the unsettled conditions on Inpatient might have been exacerbated by implementing an innovation, the Service Director felt that no work on the POR should be attempted until the service stabilized.

During this period, R&E personnel periodically discussed the POR approach with the Service Director and provided reprints of materials to key staff. R&E was recommending the Problem Oriented Record as a more appropriate approach than such alternative techniques as Goal Attainment Scaling. First, POR is a medically oriented system, an important consideration in a unit physically and professionally attached to the medical center. Weed's original work (1969) stressed the relationship between medical records, training and quality care on medical units. However, the POR has led to a rich literature, including work on the psychiatric use of this approach (Grant and Maletzky, 1970; Hays-Roth, Longabaugh and Ryback, 1972; Katz and Woolley, 1975; and Ryback and Gardiner, 1973). Considerable information is also available on how other professionals, including nursing, have used this approach.

An additional consideration was the availability of materials from other institutions utilizing the Problem Oriented Record. In particular, forms and instructions from the Osawatomie State Hospital, Osawatomie, Kansas; Fairfield Hills Hospital, Newtown, Connecticut; and the Johnson County Mental Health Center, Mission, Kansas were useful. Finally, there are local individuals and organizations with experience in implementing POR approaches in mental health settings.

The major characteristics of the POR include a data base, problem list, list of assets and resources, treatment plan, progress notes and termination summary.

Data base consists of a description of the patient, his chief complaint, present illness, past history, family history, physical examination, mental status, psychological testing data, laboratory, and consultant reports, etc.

Next, a numbered and titled list of problems is drawn from the data base. A problem is "any specific derangement that interferes with the patient's enjoyment of life". This list should include all relevant past and present problems. The major types of problems are:

1. Medical
2. Psychological/Psychiatric
3. Social

Then comes a list of assets and resources which includes factors that can be useful in assisting in the process of recovery and the maintenance of health. This list includes salient points of the patient's existing or potential character strengths, vocational skills, talents, as well as resources and supportive factors within the family and/or community.

The initial treatment plans represent the first approaches to patient diagnosis, treatment, and education. These are listed for each problem as treatment begins, and are continued and modified in the progress notes.

Progress notes are numbered and titled as on the problem list. They reflect accomplishments, the course of problems and their treatment. The main principle governing the format of a progress note is the separation of fact from assessment (separation of a test result from an observation). For this reason, progress notes are structured according to the SOAP (Subjective, Objective, Assessment, Plan) Format or the NAP (Narrative, Assessment, Plan) Format.

Finally, termination or discharge summary. This takes the form of an enlarged progress note. The unresolved problems should be discussed in greatest detail, to assist any therapist who might become involved later. At the end, a current patient profile and the currently active problems should be listed, along with the treatment recommendations and ongoing treatment interventions. This is especially useful in transferring a patient from one treatment setting to another.

At present, the Inpatient Service is just beginning concentrated work on the POR. The Research and Evaluation Service prepared and presented to the administrative staff, a breakdown of the characteristics, advantages and disadvantages of the POR. Discussion revealed significant areas of staff concern which are now being worked through. At R&E's suggestion, the unit has established a clinical records committee initially chaired by the new Head Nurse, Anne Donabedian. She is familiar with and committed to the innovation because of her work at other Inpatient Units.

The professional sophistication, high level of competence, and unsettled internal conditions on Inpatient limit the present development of a comprehensive implementation strategy at this time. The goal of the R&E Service is to continue frequent contacts with the service administrators, participate in the committee and provide any needed technical assistance as the Service harnesses its considerable internal resources and commitment to treatment excellence to develop a variant on the POR approach.

Task V: The Problem Oriented Record on Crisis Service

The Crisis Service consists of Alcohol, Drug and MH/MR Crisis Units. It is closely linked with the Inpatient Service, in that both services have

similar staffing patterns and the Director of Crisis Service, John Ebert, also serves as a psychologist on the staff of the Inpatient Service. This Service is open 24-hours a day and sees approximately 200 clients a month.

Until the situation on Inpatient is clarified, no further action will be taken to implement the POR on Crisis Service. The Service's Director and key staff are aware of the characteristics of POR and the Director is on the clinical records committee of the Inpatient Unit. The linked nature of these services means that the development of a clinical records system should be parallel and complementary, and some initial work has been done. Of particular concern to the Service Director is that his system: 1) should be easily learned by part-time, on-call staff, and 2) should be able to generate high quality data suitable for research projects. A modified POR incorporating behavioral checklists and standard sets of problems should accommodate these concerns.

SUMMARY

These five case histories illustrate how a general mandate to upgrade clinical records led to five related projects. These projects are ongoing and all will require work in the future. Additionally, there have been a number of spin-offs from this work. Different services in the Drug and Alcohol Programs are beginning to work with the systems developed on MH/MR units. Federal support has been sought for a comprehensive study of the effects of the innovations on the MH/MR services and on the clients who move through the CMHC. Much of this work will also be reported at an evaluation training conference sponsored by Crozer-Chester Medical Center, Delaware County MH/MR and the Pennsylvania Evaluators Network.

(INITIAL GOAL ATTAINMENT SCALE FORM)

1. _____
Client Name

2. a. _____ b. _____
Date of Intake Interview(s)

3. _____
Intake Interviewer

4. _____
Recommended Follow-up Time

5. _____
Approved for Follow-up

6. _____
Follow-up Interviewer

7. _____
Date of Follow-up

8. _____
Persons Involved in Construction of the Goal
Attainment Follow-up Guide

- _____ a. Both Clinician and Client
_____ b. Contract Fulfillment
_____ c. Client Only
_____ d. Clinician Only
_____ e. Other (e.g., Family Member, etc.)

I. CLIENT INFORMATION

A. NAME:		CHANGE OF STATUS		A. ☐ EMERGENCY, or action within _____ days.		☐ Transfer ☐ Referral ☐ Discharge	
Phones: (H) _____ (W) _____		Employer: _____		Crozer-Chester CMHC Chester, Pa. 19013		B. S.S. Number: _____ B.S.U. Number: _____	
STREET: _____		UNIT: _____		C. PRESENT UNIT: _____		Contact Person: _____	
TOWN: _____ Zip: _____		Catchment Area: Lives: _____ Works: _____		Admission Date: _____		Date of Change: _____	
B. Can Also Contact: _____		C. Sex: _____ Age: _____ B.D.: _____		Marital Status: _____		1st Contact Respon of: ☐ Client, ☐ New unit or prior call made to: _____	
Race/Ethnic: _____		Educa./Grade: _____		Religion: _____		Total Number Units of Service:	
D. 3rd Party Coverage: ☐ None ☐ MA ☐ DPA ☐ SSI ☐ BC/BS ☐ Other		Max. Liability \$ _____ mo. _____		Employed: ☐ Full ☐ Part ☐ No		Occupation: _____	
E. RECENT CHANGES: ☐ Work ☐ Family ☐ Health		AVAILABLE: ☐ Work ☐ Church		SUPPORTS: ☐ Family ☐ Other		D. NEW UNIT 1st Contact made by: ☐ Client or: _____	
F. DIAGNOSIS (Psychiatric/Medical):		Code		Private MD is:		Date 1st Contact: _____ Date 1st Interview: _____	
1 _____		_____		☐ Suicide risk		☐ Accept ☐ Re-transfer ☐ Close	
2 _____		_____		☐ Alco Abuse		Treatment Plan or	
3 _____		_____		☐ Drug Abuse		Re-transfer date: _____	
4 _____		_____		☐ Meds Abuse		Date 1st Treatment: _____	
				☐ Meds Reaction		Signed: _____	
				☐ Other Med. Prob.			

III. TYPE CHANGE

A. DISCHARGE STATUS: ☐ Not a discharge ☐ With Prog. Advice		2 Against Prog Advice: _____ 3 Other: _____		C. REFERRAL TO (outside CMHC) Code: _____	
B. TRANSFER TO (within CMHC)		D. MEDICATIONS at Change: _____		00 No Referral made	
				01 Approp. Referral Unavail.	
				02 Self/Family/Friend	
				03 Clergy	
				04 Non-psychiatric physician	
				05 CCMC (except detox)	
				06 Other Medical Facility	
				07 Nursing Home	
				08 Priv. Prac. MH Professional	
				09 State Hospital (MH)	
				10 Other MH (ind BSU I, II, III)	
				11 MR Facility or Program	
				12 Community Social Agency	
				13 Resident Drug Program	
				14 Out-Pt. Drug Program	
				15 Resident. Alcohol Program	
				16 Out-Pt. Alcohol Program	
				17 School System	
				18 Parole/Prob. Officer	
				19 Other Crim. Justice	
				20 Employer	
				21 Commun. Organiz/Club.	
				22 Voc. Rehab. Program	
				23 Other:	

IV. NEW UNIT V. REMARKS

A. STATUS ON NEW UNIT: ☐		B. NEW TREATMENT PLAN: _____		Frequency _____ Duration _____ Prognosis _____		Medications Prescribed: ☐ NONE, or _____	
1 New on Unit		☐ Individ.				Staff Assigned: _____	
2 Readmiss, 1 mo.		☐ Group					
3 Readmiss, 3 mo.		☐ Family					
4 Readmiss, 6 mo.		☐ Day/Night					
5 Readmiss, 1 year		☐ Residen					
6 Read. 1 + yr. (opt.)		☐ Other					

- INTAKE -

APPENDIX A1a

CLIENT INFORMATION

A. NAME		INTAKE FACE SHEET Crozer-Chester CMHC Chester, Pa. 19013 UNIT:		A. ☐ EMERGENCY, or action within: _____ days																													
PHONES (H) _____ (W) _____				B. Contact # or S.S. _____ B.S.U. Number _____																													
STREET _____		TOWN _____ Zip: _____		C. FIRST CONTACT																													
B. REFERRAL SOURCE: _____		C. Principal Presenting Problem: _____		Staff Initials: _____ Date: _____ Time: _____ ☐ am ☐ pm Type: ☐ Phone ☐ Walk-in ☐ Other: by: ☐ CLIENT and/or: Decision: ☐ Accept ☐ Close ☐ Transfer to: ☐ Referral to:																													
D. Sex: _____ Age: _____ B.D.: _____ Marital Status: _____		Race/Ethnic: _____ Educa/ Grade: _____ Religion: _____		D. INTAKE																													
E. ADMISSION STATUS: ☐		RECENT AGENCY CONTACTS ☐ NONE, or below (*Rec. Req.) <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Year</th> <th>Facility Name</th> <th>Duration</th> <th>Person to Contact</th> </tr> </thead> <tbody> <tr><td>1 Now on Unit</td><td></td><td></td><td></td></tr> <tr><td>2 Readmiss, 1 mo.</td><td></td><td></td><td></td></tr> <tr><td>3 Readmiss, 3 mo.</td><td></td><td></td><td></td></tr> <tr><td>4 Readmiss, 6 mo.</td><td></td><td></td><td></td></tr> <tr><td>5 Readmiss, 1 year</td><td></td><td></td><td></td></tr> <tr><td>6 Read. 1+ year. (opt.)</td><td></td><td></td><td></td></tr> </tbody> </table>		Year	Facility Name	Duration	Person to Contact	1 Now on Unit				2 Readmiss, 1 mo.				3 Readmiss, 3 mo.				4 Readmiss, 6 mo.				5 Readmiss, 1 year				6 Read. 1+ year. (opt.)				Date of 1st Interview: _____ Decision: ☐ Accept ☐ Close ☐ Transfer to: ☐ Referral to: Treatment Plan Date: _____ Date 1st Treatment: _____ Signatures:	
Year	Facility Name	Duration	Person to Contact																														
1 Now on Unit																																	
2 Readmiss, 1 mo.																																	
3 Readmiss, 3 mo.																																	
4 Readmiss, 6 mo.																																	
5 Readmiss, 1 year																																	
6 Read. 1+ year. (opt.)																																	
F. 3rd Party ☐ None ☐ MA ☐ DPA ☐ SSI ☐ BC/BS ☐ Other: _____		Max Liability \$ _____ mo. _____																															
Employed: ☐ Full ☐ Part ☐ No Occupation: _____		G. Recent Changes: ☐ WORK ☐ FAMILY Available ☐ WORK ☐ CHURCH ☐ RES. ☐ HEALTH Support: ☐ FAMILY ☐ OTHER: _____																															
H. Family MD is: _____		☐ Suicide attempt ☐ Alco Abuse ☐ Meds Abuse ☐ Other Signif. ☐ Suicide gesture ☐ Drug Abuse ☐ Meds Resct. ☐ Med. Prob.																															
I. SIGNIFICANT OTHERS: ☐ NONE, or beldw (✓ person to contact: * if NOT living with client now)																																	
Same Surname	Age	Sex	Relat.	Full name	Age Sex Relat. Address/Phone																												

III.

TREATMENT

A. INTAKE PROCEDURES: ☐ Standard Interviews ☐ Psychological Test (s) ☐ Physical Examination ☐ Liability Worksheet									
☐ Psychiatric Interview ☐ Mental Status Test ☐ Urinalysis ☐ Other:									
B. INITIAL DIAGNOSIS (Psychiatric/Med) Code _____									
<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>1</td><td> </td></tr> <tr><td>2</td><td> </td></tr> <tr><td>3</td><td> </td></tr> <tr><td>4</td><td> </td></tr> </table>		1		2		3		4	
1									
2									
3									
4									
C. TREATMENT PLAN: Frequency _____ Duration _____ Prognosis _____									
☐ Individual ☐ Group ☐ Family ☐ Day/Night ☐ Resident ☐ Other:									
D. MEDICATIONS PRESCRIBED: ☐ NONE or: _____									
E. Staff Assigned: _____									
F. Other Agencies Indiv. involved: ☐ NONE or: _____									
G. External Pressure: ☐ NONE or: _____									

IV.

REMARKS

Continued on: ☐ back of page ☐ Intake Summary Sheet

CROZER-CHESTER MEDICAL CENTER

UPLAND, CHESTER, PENNSYLVANIA 19013 - (215) 874-9611

We are employing a system in Partial Hospitalization which is designed to help you and me together to define problems that you would like to work on while you are in this program. We will work together to come up with some specific goals that you would like to work toward. This will give us an idea of what we could do on the Unit to help you and others to a greater extent.

An important part of this system is to find out how successfully you have been able to achieve these goals.

To do this we need your permission to make contact with you by telephone after you have completed the program. We will ask you how you feel you have achieved your specific goals and how much you feel that this program has been able to help you.

I give my permission for a staff member of the Crozer-Chester Community Mental Health Center to make contact with me in approximately six months to find out how the Day Hospital Program has affected my areas of concern.

Signed: _____

Date: _____

Witness: _____

1-17-75

LEVEL OF FUNCTIONING AT INTAKE

(Goal Attainment Scaling Form)

Much less than expected	Much less than expected	Much less than expected	Much less than expected	Much less than expected
Less than expected	Less than expected	Less than expected	Less than expected	Less than expected
Expected	Expected	Expected	Expected	Expected
More than expected	More than expected	More than expected	More than expected	More than expected
Much more than expected	Much more than expected	Much more than expected	Much more than expected	Much more than expected
D.N.A.	D.N.A.	D.N.A.	D.N.A.	D.N.A.

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Appendix A3

Vocational/Educational

9. Client does not care for personal needs.
8. Currently unemployable or cannot attend school. Performance minimal self care functions only and requires supervision.
7. Not working now but potentially employable. Rarely attends school but takes care of self with minimal supervision.
6. If working, performance is clearly unsatisfactory. School attendance irregular and student is failing. Does assume responsibility for basic self care.
5. Work performance or attendance irregular. School attendance regular but near failing.
4. Work performance barely satisfactory, many D's due to barely satisfactory school performance.
3. Work performance satisfactory, school performance C or better, no failures.
2. Good work performance, B level performance in school.
1. Excellent employee or A level student.

Socialization

9. A physical danger to others in social unit, peer group or community or is totally withdrawn.
8. Constant, damaging physical aggression or nearly complete withdrawal makes client unacceptable to social unit, peers and/or community.
7. Repeated, constant physical altercations or withdrawal from all but a few. Causes severe strain on social unit, peer interactions or community interactions.
6. Able to interact with others but frequent minor physical aggression or withdrawal in some situations causes constant strain on interactions.
5. Can function socially but poor social skills or frequent, verbal aggression cause frequent strain in interactions with peers, social unit or community.
4. Can function adequately in some social groups but verbal outbursts cause occasional strain in interactions.
3. Can function socially in most groups but verbal outbursts cause occasional conflict within social unit, with peers or in community.
2. Functions appropriately socially, outbursts and conflicts with others rare.
1. Social skills are well developed, anger and interactions appropriate.

Self Worth/Depression

9. Total apathy, Dysphoria.
8. Deep depression. Integrated suicide attempt.
7. Serious, agitated depression or immobilizing anxiety attacks. Ruminations about suicide or serious gestures.
6. Great anxiety or depression. Suicidal gestures or threats and/or constantly low self-esteem.
5. Depression is frequent and moderately serious, or anxiety attacks are frequent and moderately severe. Low self-esteem, manipulative suicide gestures or threats.
4. Depression and anxiety are moderate but occasional. Occasionally client feels completely useless.
3. Depression and anxiety - mild and occasional. Client often unhappy with self.
2. Rarely unhappy or anxious but occasionally lacks self-confidence.
1. Happy, well-integrated, self-confident.

(BSU Only)

 GROSSER-CHESTER CMHC
 1 E. 9th St., Chester, Pa.

BSU # APPENDIX A4c

Page of

REA	PROBLEM	GOALS	TREATMENT	DATE	REMARKS
/E oc /D	1 Serious Suicidal gesture or possible overdose	1a Explore meaning of possible gesture with client	Three individual counseling sessions	1/5/76	Reformulated as problem 2+3
/E oc /D	2 Suicidal gesture	2a Explore + clarify relationship with mother	Family therapy 5 sessions	1/19/76	Gesture directed against mother
/E oc /D	3 Drug Abuse	3a Stabilize present non use of drugs	Continue individual sessions	1/26/76	See 3b
/E oc /D	↓	3b Work with client to enter drug program	↓	1/26/76	See 3b
/E oc /D	4 Lacks High School Diploma	4a Entry into GED Program	↓	2/9/76	Entered GED Program 2/16/76
/E oc /D		3b	Referred to Outpatient Drug Clinic	2/16/76	Accepted into Service 2/20/76
/E oc /D		4b		2/16/76	Initially quite success- ful in GED Program.
/E oc /D		2a		2/16/76	Client has moved in with father

REA OF FUNCT.	INITIAL			REVIEW 1			REVIEW 2			REVIEW 3			REVIEW 4		
	Score	Wt.	Sum	Score	Wt.	Sum	Score	Wt.	Sum	Score	Wt.	Sum	Score	Wt.	Sum
oc/Ed	4	1	4				4	1	4				4	1	
ocial	4	1	4				7	3	21				5	3	
W/Dep	7	3	21				6	2	12				5	2	
otal			29			29			33			33			
Signature															
ate:	1/5/76			1/12/76			1/19/76			1/26/76			2/2/76		

AFFIRMATIVE ACTION AND COMPREHENSIVE PLANNING IN SERVICES FOR THE ELDERLY

by Marlene G. Patterson

This is a hypothetical case that represents a composite of several real and several fictional situations. Names and places have been changed to preserve privacy.

The setting

Lo-west county is located in North Central state. Its inhabitants number approximately two million. One and a half million residents are found within the central city; half a million persons reside in the suburbs which ring the city. The county has an area agency on Aging (known as a triple A agency) which administers the federal and state funds for social services for that nineteen per cent of the population over sixty.

The presenting problem

The Regional Aging Specialist from the state received a complaint from the local chapter of the Urban League, an advocacy organization dedicated to social and economic development in the Black community. The complaint addressed the activities of the AAA, charging discrimination in its operation in regard to clientele, services and board composition. It was the job responsibility of the Regional Aging Specialist (RAS) to monitor all phases of the activities of the AAA, including affirmative action.

The executive director of the AAA, a Black man, had been on the job approximately six months. He was very much aware that the agency lacked a comprehensive affirmative action plan although it advertised the fact that it was an equal opportunity employer. The budget and a series of emergencies had pushed the development of an AAP down to a lower rung on the list of priorities. He decided

that this was an opportunity for innovation and organizational change. He pushed for the definition of the problem as a planning one, feeling that a comprehensive plan could be developed with the AAP as its core. An audit of the current situation regarding minorities and a needs assessment study of aging population could form the base of such planning. Fortunately, the executive director of the AAA and the state Regional Aging Specialist concurred in this approach. They saw this impetus from the Urban League as an occasion to unfreeze old behavior and to encourage the generation of several developmental programs that would be expected to have some long range repercussions.

Comprehensive planning for the aging was in keeping with the recommendations from the Post-White House Conference on Aging Reports, 1973 and guidelines from federal and state government.

"To be responsive, planning must involve inputs from many segments and sectors of our society. To be effective, this planning must be comprehensive and coordinated".

The Urban League, as advocate for the Black aged and the poor aged of all races, noted that certain programs were specified as target group programs, aimed at certain high risk groups such as the minority elderly and the poor elderly. Not only should there be no discrimination against minorities and the poor in the expenditure of government funds, but cognizance of their special problems should lead to affirmative action to correct and eliminate these. The League charged that 60% of the budget went to subcontracting agencies delivering services from centers with a predominately white middle class clientele. The centers were physically not located in neighborhoods with sizeable minority and poor populations. This was true for ten out of twelve centers. The activities attracted a younger, more mobile, better educated group that displayed the more socially acceptable traits such as adequate personal care, grooming and sociability. Blacks and other

minorities accounted for 46% of the population as a whole in the city and 20% in the suburban section of the county. Sixty percent of the aged population had incomes of \$2000 or less. The composition of the boards of directors at the centers reflected the clientele and the neighborhood. (The city ranked sixth on a list of the most segregated by housing patterns, in the country).

The underlying problem

1. Full participation by all income and racial groups in community affairs was still not a reality in Lo-west county. The distribution of power and political influence was such that the White upper and middle-income residents were able to exert an influence beyond their number. Ten out of twelve sub-contracts from the AAA went to social service agencies that reflect these interests. Moreover, these agencies have tended to offer services that fit their program capability rather than develop programs for the high-risk aged. The more powerful groups got the greater share of money and services.

2. The program for the elderly in Lo-west county was set into operation without an adequate planning mechanism, comprehensive in scope, that could be responsive to the full range of needs in the population it was supposed to serve.

The group affected most adversely and directly was the minority and low-income elderly, although the entire community eventually paid. The dollar cost of projected preventative programs and maintenance care was minimal compared to the cost of care for a full-blown crisis episode. For example, the cost of a home health aid for a few hours, transportation to the hospital, and an occasional physician's fee was less than the cost of one day's care in a skilled nursing facility (estimated at \$80. for the City facility) or hospital care for one day (estimated at \$120. for the City hospital). The families of the high-risk elderly and the community-at-large of necessity, eventually absorbed the greater costs. This included the elderly with more resources, both minority and majority

group members. They, like their less advantaged peers, were deprived of the opportunity for participating in the planning and evaluation of services for themselves.

The AAA executive director was persuasive enough to convince the state official to support the expeditious development and implementation of the Affirmative Action Plan as part of a comprehensive planning system. He described affirmative action as a management-by-objectives approach. He argued that the Urban League had called attention to the fact that there existed differences in the aged population that must be considered in program planning: life style, education, degree of disability and infirmity, religiously and culturally determined preferences, degree of past deprivation, etc. His concern was to avoid the morass of racial politics while optimizing individual, structural, and organizational factors which facilitate change. Towards this end, he urged the formation of a special task force, to be charged with the construction of a comprehensive plan. The issues to be addressed by the task force included the following: 1. How should funds be used? (i.e. the most needy case or the case most accessible to intervention); 2. What types of program should be purchased? (nutrition, recreation, social services, outreach, coordination, etc.); 3. Who makes the decisions? What part does politics play? How may community input be assured?

Members of the task force

In the selection of the Task Force members, an effort was made to have representation from the key interest groups in the community in regard to services for the elderly. These persons were balanced by individuals who represented expertise in the areas of planning and aging or who represented the interests of government at the state and local level.

Members

XXXX XXX

XXX XXXX

XXX XXXX

XXXX XXX

XXX XXXX

XXXX XXXX

XX XXXX

XXX XXX

XX XXXX

Organizational Affiliation

County Welfare Department

Mayor's Office, Lo-West

Urban League

Area Agency on Aging

Welfare Rights Organization

Council of Voluntary Agencies

Council of Churches

Federation of Jewish Agencies

Planning Consultant

Charge to the Task Force

1. To develop a comprehensive affirmative action plan for the area Agency on Aging to include, but not necessarily be limited to the areas of:

- a. Recruitment, Hiring and Promotion
- b. Staff Development with the focus on Affirmative Action
- c. Composition of the Board of Directors of the Agency
- d. Selection of programs and services to be funded
- e. Selection of subcontractors
- f. Establishment of priorities in regard to clientele

2. To develop plans for the participation of consumers, consumer advocates, service providers, and government agencies in establishing programs and priorities.

3. To develop plans to encourage the adoption of affirmative action plans by all subcontractors in regard to employees, clients, programs and boards.

Mission of the Area Agency on Aging (AAA)

It was the organizational mission of the AAA to administer funds from the

federal and state governments to the county for services to the elderly. Funds were used for any of the services specified on a list developed at the federal level in conjunction with the enabling legislation:

Protective services	Counseling and casework
Day care services	Home health aides
Information and referral	Homemaker services
Nutrition programs	Chore services
Recreation and socialization	Friendly visiting
Education	Outreach
Telephone reassurance	Operation Search
Transportation	

In addition, the AAA was to provide leadership in an advocacy role in behalf of the elderly and in a coordinating role for activities funded through other agencies and/or provided by subcontractors.

The Client Population

There were 232,000 persons in Lo-west county sixty-five years of age or older. They constituted a diverse group in terms of life experience, resources, racial and ethnic background, and level of self-sufficiency. Forty percent of the elderly in the 1970 census were Black, forty-four percent White and six percent were other minorities, mostly Puerto Rican and Mexican American. Several subsets within the population were identified for high priority consideration.

Those persons with an income of \$2000 or less a year constituted 60% of the population 65 years of age and older.

	<u>Black</u>	<u>Spanish Speaking</u>	<u>White</u>
Female	83.4%	77.3%	67.5%
Male	59.8%	40.4%	34.0%

Group I. Elderly with income of \$2000 or less by race or ethnic group and sex.

These demographic groupings did not represent organized political or social entities.

Group II. Those elderly who are limited in major activity due to chronic condition and who have family income under \$3000 constituted 45% of the population sixty-five and over.

Group III. Those persons with long term disabilities, residing outside of institutions, composed 12% of the 65-74 age group and 20% of the seventy-five and older age group.

The Task Force Recommendations

The force recommended that 70% of the budget be used for services to these three groups for the first year. Recognizing the potential unpopularity of this allocation, a skillful public information campaign was to be mounted to offset adverse public opinion. Within the year, more specific needs assessment studies were to be completed. Using census tract information, Operation Search, a door-to-door outreach project, was to gather detailed data regarding needs while also providing information and referral services.

The remainder of the budget was allocated as follows:

- 10% administrative costs
- 2% community wide information, public relations and educational programs
- 18% services to other elderly, including education (basic literacy and other programs), center based recreation and nutrition programs.

Program for Affirmative Action and Comprehensive Planning

Goal I. The adoption and implementation of a comprehensive Affirmative Action Plan to include reference to personnel policies, composition of the board of directors, client target group and the type of programs and services funded.

Objective

1. That the agency be an equal opportunity employer and demonstrate its commitment to the elimination of discriminatory employment practices against minorities (Blacks, Puerto Ricans, Native Americans, and Americans of Asian descent); women, the physically disabled; and the older worker.

Sub-objective 1

1. The staff of the agency should be representative of the population of the county in racial and ethnic configuration.

Strategies

1. Broad recruitment for positions, using ethnic newspapers, specialized minority employment agencies.

Assessment criteria - The inclusion in the annual AAP report samples of newspaper and journal advertisements. A summary of the steps taken to reach a broader audience. Annually, this tactic was to be reviewed in terms of the number of minority candidates in the applicant pool and to be modified as needed.

2. In an attempt to rectify past inequities, particularly in regard to minorities and women, preferential consideration was to be given candidates from these two groups who meet or exceed the minimum requirements.

3. Numerical goals were to be established as targets.

These would be estimates based on the number of women and minorities one would expect to find in each occupational pool if there were no discrimination.

Assessment - The annual AAP report would indicate the impact as revealed in the number of employees in each of the special groups mentioned in Objectives I. Number hired would be compared with targets. If there is a wide

discrepancy, an explanation was to be included in the report. The employment profile would be stratified into administrators and professionals; clerical and technical staff; and support staff.

Sub-objective 2

Opportunities for advancement and for increased monetary compensation were to be offered on a non-discriminatory basis.

Strategy 1

1. Pay scales were to be established for all positions. These were to be posted in the annual report. Special stipends were to be provided to assist relocation for job categories where the local pool of candidates is insufficient.

2. Information regarding training and educational programs would be announced to all appropriate staff.

3. The agency's position as an equal employment opportunities organization would be publicized.

4. The establishment of a grievance procedure within the organization in regard to AA.

Assessment - An annual review of the personnel policies and the AAP report for the inclusion of the above items.

Strategy 2

A workshop was to be conducted for employees on affirmative action: the rationale of the concept, strategies and assessment techniques. The need for commitment and knowledgeable participation at every level in the organization was to be stressed.

Assessment - No attempt would be made to directly assess learning and attitudes. Attendance at the workshop was to be used as a proxy measure.

Objective

2. That the Board of Directors of the agency be broadly representative of the community. The Board was to include consumers, advocates for consumers, minorities, women, one or more persons under thirty-five and several persons over sixty-five.

Strategy 1

Board members were to be recruited with these categories in mind.

Assesment - A profile of board members was to be maintained with these characteristics noted. A summary was to be presented in the annual AAP report.

Objective

3. That the funds of the agency be used in such a way that minorities did not benefit to a lesser degree than the dominant majority.

Sub-objective 1

That minorities be represented in the client group at a minimum, in proportion to their number in the elderly population as a whole.

Strategy 1

Target group planning.

Assessment - Measure numerical outcomes in terms of numbers of minority elderly served against numerical objectives.

Sub-objective 2

That programs and services were not adopted across the board that had limited appeal for significant portions of the minority elderly. (For example, rather than contract food services to one caterer on a county-wide basis, a decentralized model could be adopted that would encourage cuisine in keeping with ethnic preferences.)

Strategy 1

Target group planning.

Assessment - Presentation of alternate plans to address stated needs for different population subsets. Presentation of social and cultural rationale for the selection. Indicate the number taking advantage of the service in ratio to the number the program was designed to serve.

Strategy 2

Workshop on planning including affirmative action to be conducted for Board members. Additional community people representing a pool of potential Board members would also be invited.

Assessment - No direct measure of learning or attitude development would be used. A questionnaire on the perceived relevance and usefulness would be given participants.

Goal II

The development and implementation of Affirmative Action Plans by subcontractors in relation to employment policies, Boards of Directors and clients.

Objective

1. That the subcontractor be an equal opportunity employer.

Strategy 1

A signed statement to this effect was to be a part of the contract.

Strategy 2

Subcontractors would be required to submit an AAP.

Objective

2. That subcontractors enhance or acquire new skills in comprehensive planning for both affirmative action and services for the elderly.

Strategy 1

Workshop on planning and intergroup relations to be conducted for selected staff from the subcontractors by consultants designated by the Task Force.

Assessment - No direct measure of learning or attitude development would be used. A questionnaire on perceived relevance and usefulness would be used as a proxy measure.

Objective

3. That the AAP and planning and evaluation activities become part of the subcontractors routine behavior.

Strategy 1

The requirement that this be included in the annual report.

Goal III

Development of a community-wide planning capability that provided for participation by consumers, consumer advocates, public and private providers and government agencies.

Objective

1. That community people have access to professional planners or the opportunity to develop skills in this area themselves.

Strategy 1

A workshop on planning would be conducted for consumers and community people.

Objective

2. That the priorities be set with broad community participation, for types of programs and services and for specification of special target groups.

Strategy 1

An annual meeting was to be conducted, at which time position papers would be presented and formal resolutions passed. The staff of the AAA would be responsible for conducting this.

Assessment

It would be difficult to assess the quality of the participation and

resolutions formed. A balance of the points of view, both majority and minority, evident in the community, was to be sought. Critical considerations would be as follows: Was there participation of different groups, including minorities? Was there evidence of concern for the most disadvantaged?

ORGANIZATIONAL CHANGE IN SPECIAL SERVICES FOR PUBLIC EDUCATION

by Laura J. Lee, A.C.S.W.

The situation to be described occurred during the early seventies. Public civil rights demonstrations were subsiding. Nationwide attention was being focused on individual civil rights and liberties of special groups of people. In the social welfare arena, the rights of clients, the call for accountability and the issue of confidentiality were highlighted phenomena.

Public education was being scrutinized. The organization to be described is Special Services (S.S.) an umbrella type sub-division of a Board of Education. S.S. was originally established to handle any problems or situations that did not come under the purview of the principal of a school and a regular classroom situation. By the late sixties, S.S. personnel were responsible for the implementation of special education, school transportation, health care, attendance problems, school counseling, psychological testing and social service. (There were two B.S.W. social workers). The total population in the school system was 21,000 students.

In 1970, the State Department of Education enacted Title 18A, Chapter 46 which superseded all previous rules and regulations pertaining to special education. The basic mandate was for standardized service to all school age children. Guidelines were set forth governing service to handicapped children and required local school district compliance for reimbursement. The Child Study Team (CST) was located in S.S. In addition, S.S. received Title I federal funds to provide supportive services to students eligible for participation in Title I programs.

The overall aim of the CST in the school system was to provide professional assistance and a supportive resource to all students as needed as a means of

maximizing educational experience commensurate with individual student's needs.

The CST had the mandated responsibility for examining, classifying, and recommending educational programs for students considered to be handicapped or needing special help. The next step was evolving and recommending individually tailored educational programs. The State Department of Education determined that a basic CST consisted of a social worker, psychologist, learning disability teacher consultant (LDTc) and appropriate medical personnel. Depending on the nature of the student's difficulty CST might have also included medical specialists, school nurse, school administrator, reading and guidance personnel, speech correctionists and classroom teachers.

Referrals were made by the teacher, parents, principals, CST members, community agencies and any other source. In one out of every four cases referred, CST revealed needs other than the original referring need. One school district estimated that approximately 46 professional hours were used per case. After case evaluation, CST then considered educational alternatives. They also participated in educational planning and curriculum development with school and administrative personnel. Preventive screening of kindergarten and first grade pupils was expected.

Between 1970 and 1972, the local Board of Education hired an additional nine social workers, six psychologists, eight LDTc's and new clerical staff. This brought the total CST members to 35 persons, excluding clerical staff. One S.S. director was dismissed for alcoholism. A six months period without a director followed. During the period of transition, a unified, articulated plan of CST functioning was non-existent. Title 13A was pretty much ignored as the mandate had not been translated into practice in S.S.

Pressures on S.S. peaked during the 1971-72 school year. These included: the DHEW requesting an accounting of services to Title I students; the State Department

of Education strongly urging compliance with Title 18A; the School Board questioned general lack of productivity in S.S. even though S.S. staff had tripled concurrent with Board members requesting and receiving favoritism for specific students.

Community spokesmen were critical of management of cases, backlog, service delivery, predominance of White S.S. professionals serving predominately Black community; parents lambasted S.S. for treatment or negligence of their children and school personnel demanded additional assistance for students (mostly the push was to get difficult students transferred out of their schools). Community agencies criticized and frequently took advantage of S.S.'s chaos to blame them for students' problems and their own inability to find suitable residential placement for a youngster.

Internally, S.S. staff morale was low; some staff members were using the lack of organizational leadership and direction to do minimum work; interdisciplinary and intradisciplinary power struggles were rampant without designated, sanctioned leadership; frequently there were hostile, verbal confrontations between staff members; service was being offered on a personally selective basis (the creakiest or most important wheel gets the oil); staff members were not held accountable for their use of time; and accepted, written policy and practice procedures were minimal. Some tenured staff members had been Board of Education employees for up to 21 years; however, during the period of S.S.'s transition, only one staff member left and that was for maternity leave.

In terms of clients receiving service, there were 265 student cases waiting for processing. Title 18A stipulated that once a student was diagnosed as having a handicap, he must be reevaluated within a three year period. Serendipitously, a number of students were discovered who had been relegated to special classes without benefit of reevaluation for upwards to seven years. Record keeping had been subjective and haphazard. The threat of opening records to the public was imminent.

Mrs. J., a Black social worker had been employed during 1971. During the fall of 1972, the second director was appointed. One of his first maneuvers was to appoint chiefs for each of the three main CST disciplines. Mrs. J. was selected to be chief social worker over two White competitors. Concurrent with the chief social worker's appointment, the director assigned Mrs. J. the responsibility of making order out of chaos.

The double assignment brought ambivalent staff reactions. Some staff members verbalized feelings that the director had "passed the buck" - "He doesn't do anything, why should we?" Other reactions included questioning why Mrs. J. should have the freedom and power to make decisions and staff assignments. Anger and hostility were readily discernible. There were shouting matches between staff members, refusals to work with specific peers, and some few protest letters from staff to the School Board. During the next few months, there were six staff resignations.

Mrs. J. requested several meetings with Dr. O., director, to determine what was expected of her; to clarify urgent problems of the organization; to propose mechanics of staff involvement in the assessment of the organizational problems, and planning and implementation of plans. Dr. O. was agreeable to all of Mrs. J.'s proposals. It was necessary for Mrs. J. to have Dr. O.'s support and to be able to ask for it openly and directly as needed. Dr. O.'s priorities were to relieve the external and internal pressures on S.S. Mrs. J. felt S.S. could benefit by permitting staff members the opportunity to discuss their frustrations and reactions to the many pressures. These expressions would be harnessed in the direction of identifying problems and proposing solutions. All staff would be involved in assessing overall problems, as well as the status of their area of functioning, to set goals and plan the program in accord with Title 18A. Mrs. J. would

coordinate and supervise the efforts.

Mrs. J. and Dr. O. agreed to have Dr. O. call a meeting of the chiefs. At the meeting, Dr. O. explained the status of S.S. problems and that Mrs. J. would be in charge of working with total staff in an effort to put S.S. on stable ground. Former methods of operating continued as assessment and planning for the change began.

The chiefs jointly decided to meet with the respective departments and bring feedback (problems, suggestions, etc.) to the chiefs' group. Agreements from the chiefs' group would be fed back to staff. Mrs. J. chaired the concerted efforts. Progress reports on the planning process were periodically distributed to key internal and external persons after each meeting. Mrs. J. sought out Dr. O. to keep him informed and try out ideas on him. Attacks on S.S. noticeably subsided, probably because efforts were being made to improve the situation and in anticipation of the system to come.

During this period, Mrs. J. supervised social workers (4 B.S.W. and 5 M.S.W.) and clerical staff. A large percentage of her time was spent in individual, impromptu conferences with staff members other than social workers. Such sessions seemed to serve the purpose of a steam valve that kept the pressure off the larger effort - to develop a service delivery system. Mrs. J. often found herself in the position of making a critical decision when other staff members (including the director) would not risk issuing the final word.

Mrs. J.'s close peer relationships with other staff members rapidly diminished with the assignment of the larger responsibility.

After three months, the system was presented to the staff and then to the School Board for approval and implementation. The proposed system included standardized record keeping, intake procedures, and CST role performance. Guidelines

were established for staff assignments, work load and responsibilities. Plans were made for standard operating procedures (SOP); a case tracking system with time constraints was developed; a plan for staff supervision was made; job descriptions were written; and the beginning compilation of a policy and procedure manual was begun. Program changes were to be incrementally introduced on a time schedule over the next four months, until the total package could be implemented. It was expected that the change would have occurred within one year. Mrs. J. remained in the coordinator, troubleshooter position.

The program was given a Board of Education public relations treatment. Overall, responses to the efforts were favorable and cooperative.

Mrs. J. remained at S.S. until the Fall, 1974, then she took a leave of absence for further study. The director was terminated four months later, and the search began for a new director. The third director was hired 5 months later. The S.S. program sustained itself during the interval.